PHILADELPHIA, MARCH 21, 1885.

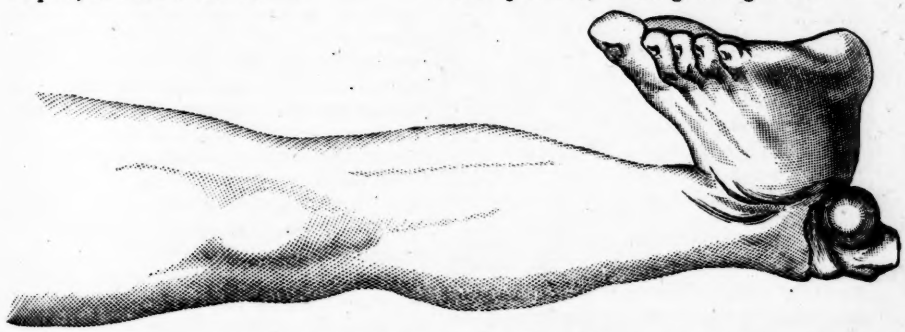
ORIGINAL LECTURES.

REMARKS ON TWO CASES OF DISLOCATION OF THE TARSUS.

Delivered at the Pennsylvania Hospital

BY THOMAS G. MORTON, M.D.,
Attending Surgeon, etc.

GENTLEMEN,—The case shown at the last clinic, of compound dislocation of the tarsus, which I told you was such an unusual accident, has since died. I remarked then that I thought the case was very rare; that I had not been able to find a similar one in the previous records of this hospital, nor had I seen any in my service, extending over twenty-one years. By a strange coincidence, a second case of the injury, almost identical with the first, except that it involved the left instead of the right foot, has been brought into the hospital, and is now before us.



The first was caused by catching the foot in an elevator; the second, by a horse falling upon the patient. The interesting features of this dislocation are well shown in the photographs, which I will now pass around for your inspection. (See woodcut.) In the case before you there was also marked inversion of the foot, almost precisely as in the other case. There was, however, in this case, as you will notice in the specimen, a fracture with separation of a small portion of the articular facet of the astragalus, which remained in place, between the malleoli. In both cases the tibia and fibula were intact.

The first patient, as you remember, was a man over 50 years of age, and his condition was such as to demand amputation of the leg. But we were unable to establish reaction in order that an operation could be performed, and he died of shock three hours after his admission into the hospital, January 19. In his case, you will remember, there was no fracture; simply a compound, sub-astragaloid dislocation of the tarsus inwards. He also received serious internal injuries, from which he died. As I told you, the results of resection after compound dislocation of the ankle-joint were not generally favorable in a man of his years and mode of life. In the present case, although he was willing to submit to amputation, we thought, after a consultation of the surgical staff, that we would be justified in making the attempt to save the foot by resection of the astragalus.

This patient is a German, 50 years of age. He is a large, robust man, apparently of drinking habits, although he says he was not intoxicated when the accident occurred. He was walking along on the ice, leading his horse, when the animal fell over upon him, crushing his leg under him.

Finding, after removing the remainder of the astragalus, that the end of the fibula projected so as to interfere with drainage, the projecting portion was removed with the bone-forceps, and after a drainage-tube had been introduced the wound was brought together, dressed with lint and carbolized oil, and the entire extremity placed in a fracture-box and covered with bran to absorb the discharges.

I am very glad to have had the opportunity of presenting these cases to you, as they are so rare that the possibility of their occurrence has been doubted by some surgeons.

[The patient did well for a time, but ultimately developed symptoms of pyæmia, of which he died, February 28.—REP.]

ORIGINAL COMMUNICATIONS.

THE DANGERS FROM COAL-GAS IN OUR HOUSES.

Read before, and publication ordered by, the Atlantic County (New Jersey) Medical Association, February 2, 1885,

BY W. THORNTON PARKER, M.D.

DR. RICHARDSON,* in his work on "Diseases of Modern Life," calls attention to impure air as "the specific cause of some diseases, the disposing cause of many." Reviewing the different conditions of impure air from crowded rooms, where the atmosphere is poisoned by the accumulation of products of respiration and excretion, devitalized air, and air poisoned by sewer-emanations, and outside influences injuring the air which supplies our dwellings, he considers the danger to health from the air which has become overheated by iron stoves, but he does not refer at all to the dangers of *carbonic-oxide poisoning*.

The severe condemnation of the average stove is well deserved, and Oscar Wilde has very cleverly called the American stoves "unpunished crimes." But Americans who have lived in England during cold weather complain of the unhealthy rooms our English cousins live in, particularly in London. The open coal-grates do not sufficiently warm the room, and, being usually of poor construction, the atmosphere is soon filled with coal-gas and smoke. On cold, raw days the occupants of these English homes huddle together around the open-grate coal fire, breathing in the irritating smoke and the deadly coal-gas, and deluding themselves perhaps with the idea that they are getting warm. Where one finds one *good* open fire in England, a hundred bad ones are also to be found. This is particularly true of the hotels and boarding-houses where strangers find temporary shelter; but even in the homes of gentlemen and well-to-do people I have noticed the abominable torment of smoke and coal-gas and the absence of reasonable warmth. And yet I believe these English homes to be far healthier than our own. Their open fireplaces offer some chance for ventilation, but our close stoves for burning coal, while they allow very much coal-gas to escape into the room, afford no suitable means for ventilation. Open fireplaces are, however, rapidly increasing in number in this country, and better stoves are being manufactured. The venerable stove invented by and named after Franklin is one of the best for health, and has many imitations. An excellent stove called the "Fire-on-the-Hearth Stove" possesses excellent features and deserves the highest recommendation. It can be used for either wood or coal as a pleasant and healthy open fireplace.†

I am not fond of our overheated American houses, but a degree of heat which saves one from fairly shivering is to be expected. I have ceased to wonder that, in spite of the splendid physique of the English, their otherwise healthy homes, excellent, well-cooked food, and admirable system of exercise, these people suffer so much from consumption. It is not fair to load the climate with the blame for all this. The source for so much of this lung-trouble in England is to be traced to the miserable smoky rooms loaded with coal-gas, and in some places the outside atmosphere is also loaded with the smoke and coal-dust and gas of the countless factories. In this country we secure the poison by other methods, and it is not *our* climate *altogether* which is the cause of so much consumption among our people.

In searching for the causes of consumption, the miserable bacilli of tuberculosis may be allowed to rest for a time in the "farms" for the rearing of this interesting and much-advertised curiosity. In battling with impure air in all its forms and by securing the destruction of the agencies developing this death-dealing monster we shall do more to save life and prevent tuberculosis than the examination of millions of bacilli will accomplish.

Impure air, how best to save our people from its depressing, poisonous, and far-reaching, death-dealing properties, should be the very *essence*, as it is the *most important*, of our investigations in preventive medicine:—how to prevent its existence; how to expel it and destroy it when found. Every one knows that few, if any, of our American homes are free from its poisonous influence. Any physician of experience must have come in contact with patients suffering from consumption and still

* Diseases of Modern Life. By Dr. B. W. Richardson. D. Appleton & Co., New York.

† A pamphlet-manual on the subject of "Sanitary Heating and Ventilating" is furnished by the Smith & Anthony Stove Company of Boston.

living, struggling to live, in an atmosphere which may have been the direct, the only, cause for the disease. The medical attendant comes daily with his prescriptions of potassium, oil, and opium, to find little, if any, change for the better in the unfortunate victim in the grip of this which is so pre-eminently a disease of filth. Nothing is said about pure air with any practical benefit. Either the patient cannot, or will not, or knows not, how to change the impure atmosphere of his home. The medical attendant often neglects to speak of the stinking, close apartments, lest his criticism might grate harshly and even meet with rude repulsion. So the farce of medical attendance goes on, until some change is made or death comes to relieve in pity. This picture is not overdrawn. It is around us all, on every side, and all over the world. I have even heard the Creator blamed for making man so weak and his lungs so vulnerable that deaths from consumption were so dreadfully frequent that it constituted a plague. A chase after the cause goes on in every direction, hunting for microscopical atoms in diseased membranes and in the products of broken-down tissues. The loathsome worms which infest the body after death might as well be reckoned the "cause of death," as the microbes sometimes found in the diseased products resulting from consumption, the *cause*, the bacilli, of consumption.

In the *Virginia Medical Monthly* for August, 1884, I have contributed a paper concerning the "Communicability of Phthisis," in which I have quoted from Green his theory concerning the cause of consumption. It is so excellent and is so related to the subject under consideration that I present it again for wider circulation:

"General feebleness and want of vigor lead to loss of muscular strength and weakness of the heart, and thus tend to prevent the full expansion of the chest, to cause a stooping posture of the body, and to impair the force of the circulation,—all conditions favoring blood-stagnation in the highest portion of the lungs; further, the toneless condition of the blood-vessels and the poverty of the blood with which the constitutional feebleness is so often associated furnish the conditions which are the most favorable to transudation. Lastly, in connection with this part of our subject, I must ask you to bear in mind that one important factor in the pathology of phthisis is the state of the general health, quite apart from any inherited constitutional feebleness; and there can be no doubt that an impaired state of health very greatly favors the development of the disease. This fact gives additional support to the view we have been taking, inasmuch as any acquired weakness must necessarily play the same *rôle* in the causation of apicial stagnation and exudation as the inherited feebleness to which we have alluded. It is when the two are associated, as they frequently are, that we have the conditions most favorable to the development of the disease.

"Whatever the communicability *possible* in phthisis, we can, by attention to the general health, and by changing the residence of incipient cases and improving the habits of our patients, do very much at present to lessen the terrors of this great plague. Undoubtedly we are but beginning to treat this disease, and before long we shall be able to offer still greater hope than at present."

In Dr. Frank Woodbury's pamphlet* "On the Rational Treatment of Pulmonary Consumption" much that I could wish to have circulated concerning the preventive treatment and the *rational* treatment of consumption is to be found.

Having thus considered some of the injurious effects of impure air, let us look more directly at the dangers from coal-gas poisoning.

Our daily papers are constantly reporting deaths from this most dangerous and highly-poisonous gas. I have reported two very interesting cases myself occurring in the practice of my father,† and it is only within a few days that I have read of some other cases in our daily journals. No one denies the deadly power of this gas in large quantities. Let us see what minute and oft-repeated doses will do, administered from the middle of October to the middle of May, each year, to millions of our inhabitants, and then let us wonder, if we can, why consumption is so prevalent in these United States! The claim that coal-gas plays so important a part in this

* Reprint from the Philadelphia Medical Times, July 15, 1882.

† "Two Cases of Poisoning with Carbonic Oxide." The Medical Index, Kansas City, Missouri, June, 1884.

scourge may seem far-fetched; but when we consider the power of this poison to destroy life we cannot doubt that its constant presence in the atmosphere of our houses must very greatly weaken and deteriorate the constitutions of those constantly inhaling it.

Our medical works afford surprisingly meagre information concerning carbonic-oxide poisoning, and our medical journals seldom report cases. A very interesting article appeared in the *New York Medical Journal* for December, 1883, but I am unable to quote from it. Boehm* says that "the quantity of carbonic oxide required to kill is not easy to estimate," and that "children succumb rapidly to the action of this poison," on account of the greater rapidity of their respiratory functions. "The first subjective symptom which occurs after breathing the poison is a burning feeling in the skin of the face (Klebs), quickly followed by giddiness and headache, which gradually becomes most intense. The chief site of this headache is in the temples. This headache or pain is generally associated with a subjective feeling of strong pulsation in the temporal arteries. Occasionally we get feelings of nausea and of oppression in the stomach and in the præcordial region. Very often, though not invariably, these are associated with a variety of subjective sensations, as motes dancing about, muscæ volitantes, noises in the ears, and the like symptoms which indicate the severance of the sensorium from the domain of reality and the transition to perfect loss of consciousness." "The access of insensibility is either a sudden withdrawal from consciousness, like a stroke, or it is preceded by pronounced phenomena of great discomfort, anxiety, nausea, and excitement, which often lead the poisoned persons to make an effort to leave the poisonous atmosphere in which they find themselves, or to try to get air by opening the windows, etc. Very often the insensibility attacks them during this very effort, so that the poisoned person falls down half-way to the window or door and lies there unconscious. At this stage all perception and consciousness of anything further are lost, so that we cannot look to the victims for any further account of themselves. The subjective symptoms which are noted in cases of recovery or restoration to consciousness are more varied and less characteristic. The most marked is a feeling of general weakness and extreme fatigue, which often lasts for several days, and accurately corresponds to the objective symptoms of this stage. Vague headaches, a want of clear conceptions, and general obscurity of the mental faculties are associated with this, as they are with many other conditions met with in a variety of other diseases. . . . In cases which end fatally the victims either never wake from the deep coma (sopor), or their awakening is only transitory and imperfect, and soon gives place to fresh attacks of insensibility and more or less suddenly leads to death."

"Besides the abnormalities of respiration dependent on the nerve-centres, we sometimes get palpable changes in the organs of respiration, which occur under the form of either acute bronchitis, hæmoptysis, or pneumonia, with or without pleurisy." Friedberg and others consider these conditions as directly dependent on the poisoning. Such is a description of the more violent forms of the disease, and, considering the prevalence of the poison, it would be hard to overestimate the injurious effects from carbonic oxide gas which must be daily inflicted upon so many thousands of people.

The following case may illustrate the action of this poison. A lady of my acquaintance, of excellent constitution, while visiting lately a neighboring city, went to her room at the hotel where she was stopping, and retired for the night. There was an open-grate fire of coal in the room burning at the time. So much coal-gas escaped into the room that not only the transom over the door was opened, but also the window was let down a little from the top. Sleeplessness caused by the coal-gas was experienced, but finally sleep overtook the guest. Upon awakening early in the morning a feeling of heaviness and pressure in the head was experienced, with sensations as if the head had been hanging down for a long time, accompanied by a sensation of deafness and suffusion of the eyeballs. The lady hurried to the window and opened it wide; and after bathing the head with cold water a violent epistaxis commenced, the blood flowing very thick and steadily. The hemorrhage lasted about ten minutes. A severe headache persisted for forty-eight hours afterwards, and the

* Ziemssen's Cyclopædia, vol. xvii. p. 464.

disagreeable head-symptoms also continued. It can be readily imagined what the result might have been had the transom and window remained closed all night.

Carbonic oxide is a violent, penetrating, and very dangerous poison, and has undoubtedly occasioned, directly and indirectly, countless numbers of deaths. In the cases occurring in my father's practice the *youngest* perished, being most easily overcome by the poison which filled the room, escaping from a leaking stove-pipe. The daughter was found dead in the bed, turned upon her face. Considerable epistaxis had occurred, and the bladder had been evacuated. In the case of the lady who was more or less severely poisoned, which I have reported, epistaxis also was observed. This fulness of the head and the very dark color and thickness of the blood I have noticed frequently in those exposed very much to the poison of carbonic oxide. The case my father saved of the two poisoned—one being already dead when he reached the house—owed her life to very prompt treatment and (in connection with the remedies administered) to *venesection.* The case reported in the *New York Medical Journal* was, I believe, saved by transfusion of blood. The evidence that the blood is early affected, and in a serious manner, and also decidedly thickened, is very well established, and venesection is, in many cases, as desirable as transfusion.

The fact that carbonic oxide is a deadly poison needs no further proof than the few remarks I have already prefaced. Its deadly, poisonous character is generally accepted. Can we not reasonably maintain that a poison so subtle in its operations, so generally present in our homes and offices, must exert a very powerful influence in causing consumption and in foiling our best efforts at cure? It is not remarkable that our lungs break down when exposed to the wear and tear they endure constantly. To this foul, poisonous carbonic oxide gas, which is so irritating and destructive, the greatest amount of harm can, I think, with reason be accredited. It is not a wonder that our delicate lung-substance breaks down, but that it is able to stand this strain of human life, in this age, so long! Our houses are heated by furnaces, stoves of various patterns for burning coal used as heaters, and more or less by kitchen stoves. Almost all of the stoves at present in use pour out into our homes, and for the destruction of their occupants, volumes of death-dealing coal-gas. It requires only a very short exposure for a healthy person in a room loaded with coal-gas to feel sick, "headachy," and generally miserable, unable either to eat or sleep,—in short, to experience in a lesser degree all the symptoms of carbonic-oxide poisoning which we have already mentioned. Where this goes on day after day and month after month, the lung-tissue shares the general impairment and becomes changed and degenerated, and diseased lung-tissue results. Referring again to Green's theory of consumption, which must be the accepted theory to-day of the majority of medical men, we find that this destructive action of the carbonic oxide gas in our dwellings is capable of and does bring about precisely this state of "*general feebleness and want of vigor*" which is the root and cause of consumption. Then "all conditions favoring blood-stagnation in the highest portion of the lungs" encourage perverted, abnormal development, and "tuberculous" deposits. Where this destruction has commenced, it is hard to stop its progress. A perverted and often malignant operation of so intense and poisonous a grade has commenced that nothing *can* quench the fire of the disease or limit its ravages. Generally speaking, these cases are so much under the influence of this abnormal action and this fever from the poisoning and malnutrition the body has so long endured that the *only chance for life is in an aseptic atmosphere,* dry and pure. Very many cases cannot improve in a moist climate like this at Atlantic City, and yet it is true that Atlantic City does afford a dryer and softer atmosphere than the average resorts east of the Mississippi. Cases which will not do well here have left to them the mountains, like the Adirondacks; and, such places failing, they should go at once to the resorts of Western Kansas, Colorado, Montana, Texas, or New Mexico,—into the only climate capable of curing consumption, a dry, moderately elevated, and somewhat equable climate (and, I might add, quite free from coal-gas).

But these Western health-sections, with the glorious, pure, dry air they offer now, can soon lose their health-giving properties. Factories and engines pouring out coal-gas will soon put an end to the pure-air supply. I do not intend to overesti-

mate the dangers from coal-gas. Dr. Richardson's list of the different agents poisoning and rendering air unfit for animal use all aid in creating our dreadful scourge of consumption, but to his list I wish to add coal-gas as the one enemy whose dangerous properties seem to be least recognized. The "Society for Instruction in First Aid to the Injured" declares, in Article II. of its constitution, that the object of the society "shall be the dissemination of information as to the preliminary treatment and nursing of the sick and injured, and as to the laws of health." What a valuable aid the physician of preventive medicine has here, ready to assist him in his mission of mercy! The amount of good this Society is capable of accomplishing, if properly supported, is simply incalculable, and every medical man and every intelligent man in this country and throughout the world must most heartily wish it God-speed. It is a noble undertaking.

We have here in Atlantic City a health-resort admirably suitable for many forms of disease and prostration.* The air is comparatively dry, and generally clear and bracing. The town is accessible to our citizens living in large cities, who need its benefits most. The feeble and convalescents can find here an almost balmy atmosphere. At least it is milder than the climate of any place within hundreds of miles, except perhaps other sections on this same coast, but which are at present not habitable in winter. The preservation of this reputation can only be accomplished by strong protection of its *pure-air supply*. Factories in the town will destroy this reputation, and neglected sanitary precautions are at work now. The safety of the city as a *sanitarium* depends upon the faithful support of the Board of Health. I notice too often the poisonous coal-gas in our streets, poured out from engine-houses or locomotives. This is not desirable, and the railroad-track would be in better place some blocks farther back: I mean for reasons of health. Pure air, wholesome food, hygiene, are the three remedies for consumption *par excellence*, but useful only when combined. These must be the treasures to be found by all at a real *sanitarium*, and the absence of these stamps the health-resort as a fraud.

In conclusion, if I have convinced my medical brethren of what they already well understand (of the dangers of carbonic-oxide poisoning), it will undoubtedly bring about some changes here and there, as far as possibilities go, in clearing our homes of much poison. As medical men, we see all about us signs of great interest in sanitary matters. The people are awakening to the necessities which are exhibiting themselves now in every direction. Life is becoming appreciated as a trust placed in our own hands, which we must protect if we would enjoy. In our homes are the greatest dangers, and the physician might almost feel discouraged as he contemplates the laborious responsibility he has assumed. We are custodians in a great measure of the public health, and our duty—our most important duty, often unpleasant, and often misunderstood, and seldom appreciated—is to man; also to battle for preventive medicine. Much can be done to-day, and much of usefulness is before us for the future.

[Since writing the above, I have read a very interesting paper in *The Sanitarian* for January, 1885, by Dr. Holden, on "House-heating and its Dangers." It is stated that "it is probably no exaggeration to say that one-half of the diseases of the present day are due to the defective hygiene of modern dwellings and tenements."]

ATLANTIC CITY, N.J., January 30, 1885.

* For further information concerning the climate of Atlantic City the reader is referred to a very interesting paper by Dr. Boardman Reed, "What Atlantic City can do for Consumptives," in the New York Medical Journal for March, 1881.

A CASE OF ADDISON'S DISEASE —WITH AUTOPSY.

Read before the College of Physicians of Philadelphia, January 7, 1885,

BY WILLIAM PEPPER, M.D., LL.D.,

Provost of and Professor of Clinical Medicine in the University of Pennsylvania.

H. P., 27 years of age, married, with a healthy family, was born and always lived in the mountains of Pennsylvania. He worked hard, and often, when in the woods hunting or lumbering with men stronger than himself, overtaxed his strength. On one occasion he hurt his back so badly as to lay him up for a week or so. He often wrenched his back in lifting heavy articles. He drank a little whiskey, smoked a little, chewed to excess, and ate his meals rapidly, but for a man in his position his habits were good. He never had syphilis, and was never exposed to such depressing influences as worry and anxiety. There was no inherited family predisposition.

He had the ordinary diseases of childhood, but was usually well until the age of twelve years. At that time his stomach began to trouble him, and he noted that indiscretions in diet would cause dyspepsia, with its usual symptoms, which would disappear when the diet was regulated. As he grew older, these symptoms of dyspepsia became more frequent and troublesome, and were often associated with spells of diarrhœa and colicky pains in the abdomen. Between the attacks the bowels were regular.

During the past six years his strength gradually failed, and for a year he had been unable to follow his accustomed avocation. His flesh was well preserved until six months before coming under observation, within which time he had lost ten pounds. For three or four years he had had a pain between the shoulders, which, however, was not very troublesome. During the past few months the dyspepsia had been almost constant, and more troublesome, and in addition there was a continual distress, and pain across the stomach running through to the back. There never were spells of vomiting with the dyspeptic symptoms, and during all this time the appetite was uniformly good.

Two and a half years ago he noticed that his color was darker than usual. This he attributed to exposure to the sun, and during the following winter the discoloration grew less distinct, but it returned with the return of spring, and last winter, instead of growing less, the color became more intense.

Upon entering the wards of the Philadelphia Hospital, October 1, 1884, he thought that the color of the cheeks was lighter than it had been six months before. The general condition had failed no more rapidly since the appearance of the discoloration than it did before. His hair had begun to turn gray at the age of twenty.

The notes upon admission state that he was apparently a well-nourished man, with dark-brown hair sprinkled with gray; the pupil of the right eye a trifle larger than that of the left (probably physiological). "He takes very little interest in anything but his family, and when away from home he suffers acutely with homesickness. Last spring he came to the hospital to stay, but ran off in twelve hours, stating that he could not stand the place. His mental condition is good, and he sleeps well. The tongue is moist, with only a little yellow coat. After eating he has a feeling of fulness in the stomach, and has a dull pain across the pit of the stomach and through into the back. This is aggravated by the presence of food, and is sometimes sufficiently severe to keep him awake. There is no tenderness, no nausea or vomiting. The bowels are costive, and since being more careful in his habits he does not have spells of diarrhœa as frequently as formerly. He has great weakness and a feeling of excessive muscular debility, and any exertion produces breathlessness, palpitation of the heart, and complete prostration. There are occasionally attacks of palpitation and short breathing even without exertion.

"The whole surface of the body is darker than natural, the discoloration being most marked on the face, where it extends from a little under the roots of the hair down over the neck to the line of the collar, and on the backs of the hands, extending to above the wrists, where the color is at least as dark as the complexion of a mulatto. It, however, has not the yellow tinge of the mulatto, but is more of a mahogany tint, as though stained with walnut-juice. It is not uniform, but is distributed in patches with little intervals of lighter-colored skin. It is not at all affected by pressure, and is not bounded by a sharp line of demarcation, but fades gradually into the surrounding skin. The lighter-colored skin is somewhat darker than the average. There is no swelling. The whole surface of the body is darker than usual, and, as he states that it is darker than it used to be, we may say that it is darker than normal. He states that the color deepens as the surface becomes cold. The finger-nails are of the ordinary tint, and contrast strongly with the dark fingers. The mucous membrane of the inside of the lips is darker than natural, and scattered over it are irregular, sharply-defined purplish patches."

An examination of the blood was made by Dr. William E. Hughes, to whom I owe this admirable history. The number of red globules was 5,130,000 to the cubic millimetre. There were 9000 white corpuscles to the centimetre, or 1 to 560 red. The red globules were a trifle smaller and a little paler than normal, and some of them deeply pigmented. The white were normal in size, some containing pigment-granules, and some deeply pigmented. There were also some free pigment-granules. I must add that his temperature was normal, or even below normal, as a rule, though on one or two occasions there was a rise to 99½° or even 101° or 101½° for a few hours, apparently due to gastric irritation.

He was confined to bed. His diet was carefully regulated, and was varied from time to time to suit the failing powers of the stomach. For the most part it consisted of milk. Several applications of the actual cautery (Paquelin's) were made over the renal region posteriorly. Internally, he took aromatic spirit of ammonia, which proved an acceptable and useful stimulant to him. He lost strength steadily and quite rapidly, and from the date of admission, October 1, to the date of death, November 18, he lost twenty pounds,—from one hundred and twenty-four down to one hundred and four pounds. The pulse grew feeble and rapid. There were from time to time unaccountable sudden failures of appetite and digestive power. He was very

low-spirited, and complaining constantly of distress and of inability to sleep quietly. Vomiting occurred occasionally during the last three weeks of his life. The pulse was barely perceptible at the wrist for two weeks before death. The discoloration grew somewhat darker towards the close. For the last forty-eight hours he was profoundly unconscious.

The post-mortem examination was made five hours after death by Prof. William Osler, assisted by Drs. Formad, Hughes, and Sykes.

Body of medium size,—fairly well-built man; moderate wasting, particularly of the face. The skin dark in color, most marked on face, neck, hands, penis, and scrotum. In those regions the color is that of a light mulatto. Rigor mortis not present. Panniculus on abdomen about one-half inch in thickness. Rectus and other abdominal muscles are of a dark-red color. The omentum is fatty, adherent to the parietal peritoneum in right hypochondrium and to front of cæcum. There is extensive perihepatitis and adhesion of the liver to the diaphragm by fibrous bands, which can with slight difficulty be torn through. The surface of rest of parietal peritoneum is a little opaque. Membrane over small intestines is smooth; over mesentery presents numerous superficial fibroid opacities (these are specially seen towards the root of the mesentery). The mesenteric and general sub-peritoneal fat *considerably increased* in amount. The coils of small intestines are somewhat shrunken. The stomach is also small and atrophic. In the preliminary dissection the right supra-renal was found firmly attached to the under surface of liver and to the side of inferior cava. No special thickening about its outer surface, but there is a fine capsule of fat. On attempting to separate the kidney and supra-renal from the liver, firm fibrous union is found. The cardiac end of stomach is attached to the enlarged left supra-renal, and the spleen and tail of pancreas are closely united to it. Kidneys, supra-renals, spleen, and retro-peritoneal tissue taken out together for dissection.

Lungs: pale; crepitant throughout; a little congested at bases; no pleuritic adhesions; no caseous masses; one or two small pigmented nodules; bronchial glands not enlarged.

Heart: loose dark clots in right auricle, projecting into veins; same in right ventricle; left ventricle in rigor mortis; left auricle contains a dark clot; valves healthy; no atheroma of intima of aorta; muscular substance a little rusty-brown in color; does not look fatty.

On removal of heart, a very considerable amount of blood exuded from the veins.

Liver: perfectly normal-looking, good color, and plenty of blood; the bile-vessels are normal.

Stomach: is very small; contains only bile-stained fluid; the cardia a little thin; mucous membrane normal.

Kidneys: of average size; color good, except immediately beneath enlarged capsules, where the tissue is soft, pale, and many of the tubes are fatty.

Intestines: cæcum and colon full of firm, hard scybala; ileum normal; Peyer's glands distinct; two inches from cæcum one long patch begins which measures six inches in length, and presents in a typical manner the shaven-beard appearance; the solitary glands are a little swollen and prominent. Bladder is full of urine; the mesenteric glands not swollen; the mesentery is very fat. No swelling of ribs, clavicles, or any of bones noted.

Spleen: slightly enlarged; closely united to diaphragm and left supra-renal by old adhesions; pulp of medium consistency.

Lymph-glands: some of the lymph-glands of the abdomen, particularly those of the mesentery and retro-peritoneal, are swollen, grayish-red in color, and several of them contain grayish, translucent nodules, with opaque centres, looking like small tubercles; some as large as peas, and the centre distinctly caseous.

Supra-renals: the right is closely adherent to the kidney, diaphragm, and inferior cava, and to the liver above. It is two and a half inches in length, one and three-quarter inches in vertical diameter, and rests upon the top of kidney, not descending into the hilus. It is exceedingly hard and firm, and on section shows a peripheral, dense, grayish-white, partially translucent tissue, and centrally three or four yellow, caseous masses, separated from each other by strands of fibrous tissue of almost cartilaginous hardness.

Left capsule: is much larger; covers the top of kidney, and descends on its inner surface well into the hilus, measuring three and a quarter inches in length, two inches vertical, and two and a half inches in thickness. The lower end of the spleen is firmly united to it, and tail of pancreas is also attached to it. The splenic artery and vein run along its anterior surface in the thick, fibroid, fatty tissue, and at one point the calibre of these vessels is very materially reduced.

The mass is extraordinarily firm, cuts with the greatest resistance, and presents identical characters with the right, except that at the most anterior region there is a pocket of creamy-looking pus, and at a central spot the caseous matter has undergone softening. At the most anterior part, close to the cœliac axis, the left semilunar ganglia is directly embedded in the fibrous tissue, and can be seen as a rounded grayish mass about one-quarter inch in diameter, and three small nerve-fibres can be seen passing from the ganglia in the dense tissue about it.

Semilunar ganglia: the splanchnics look normal, and can be traced directly into the semilunar ganglia; as the right passes on the

crus there is a small ganglion developed upon it; it is free from all adhesions; the branches are readily dissected and look normal. The left semilunar ganglion is directly involved in the fibrous tissue of the supra-renal, as stated above; the nerves of the left ganglion, as they pass out, are involved in the cicatricial tissue of the left supra-renal capsule, and cannot be dissected, but can be seen on section; several filaments can be traced to the branches of the cœliac axis.

At the concave margin between the two lunar ganglia there is a small dark-yellow body, probably a supernumerary adrenal. A bunch of normal-looking nerves passes from the right directly to the left semilunar ganglion. The branches passing to the right supra-renal can be traced in the fat and along the artery; they are neither numerous nor large.

MICROSCOPIC EXAMINATION.

Left semilunar ganglion: teased portions from the centre of it show innumerable ganglion-cells, most of which are very darkly granular, but the nuclei and in places the nerve-processes can be distinctly traced; nerve-fibres, medullated and non-medullated, are numerous, and in many places show remarkably slight change; in some cords the fibres are less distinct, fat-granules numerous, nuclei elongated, and the process of disintegration appears to be going on. In sections the ganglion-cells can be seen separated from each other by a considerable amount of nucleated tissue. In places they are still closely set together, but in others they are in a great part atrophied, and only one or two can be seen in the fibrous connective tissue, being recognized by the dark granular pigment. The section showed the nerve-fibres through the hard sclerotic tissue, and the chief change noticeable is a marked elongation of the nuclei, and, indeed, a multiplication of them.

Right semilunar ganglion: the cells are very readily isolated; the nuclei distinct, and in each instance surrounded by tolerably dense, dark, pigment-granules; the nerve-fibres appear normal.

Several portions of nerve-fibres passing out from the right semilunar ganglion were examined, none of which showed any special change; the cord of the thoracic sympathetic and the ganglia normal; the cells of the latter moderately pigmented.

Marrow from rib: it is dark-red in color, does not look fatty, and presents the characters of ordinary red marrow; many of the colorless cells are very granular and of average size; no great number of small ones; nucleated red blood-corpuscles tolerably abundant; no cells containing red blood-corpuscles.

Marrow of vertebra: rather more fatty, of a deep, rich color, and differs further from the fact that it contains a number of cells containing red blood-corpuscles; in places these are extraordinarily numerous and large.

Heart-muscle of left ventricle in a state of brown atrophy; a few of the fibres present fat-granules throughout them.

Spleen-pulp: in addition to the ordinary elements there are also very numerous corpuscles containing red blood-corpuscles in all stages of degeneration.

It will be seen that this case was a very typical one of Addison's disease, both as to its clinical symptoms and as to the lesions present. The absence of anæmia is shown by careful examination of the blood, indicating that the main cause of the symptoms was to be sought in connection with the sympathetic nervous system; and the extensive and positive lesions carefully made out by Prof. Osler in this case fully confirm this view. Undoubtedly in many cases of Addison's disease the chief cause of the symptoms is to be found in such nervous implications and lesions; but in other instances it is clear that there is a progressive anæmia associated which must play a part in causing the symptoms. In cases where the exudation in the capsules undergoes cheesy degeneration with absorption of the disintegrating organic materials, it is not improbable that there may also be an element of sepsis which would aid in inducing cachexia, even if it did not lead to tuberculosis, which, as is well known, not rarely appears in the late stages of Addison's disease.

The frequent allusion to severe strains or injury of the back in the history of this case suggests the possible origin of the disease of the capsule from repeated irritations caused by violent muscular strain or by sudden shocks to the frame. It will be noted that in a considerable proportion of cases this disease has arisen in subjects liable to such causes as the above.

REPORT ON HYGIENE.

BY HENRY LEFFMANN, M.D.

PROGRESS OF CHOLERA.

THE excitement in regard to the probable visit of cholera to this country has in a measure subsided. At the present time it is practically absent in Europe, the bills of health from Mediterranean ports recording entire freedom from the disease, and there being no evidence that it has at all appeared in English cities, except perhaps a few sporadic cases in Lon-

don. It remains to be seen whether this condition is merely one of abeyance, or whether the germ has not attained sufficient distribution.

The manner of propagation of the disease does not appear to be yet clearly established. The recently-published results of the English Commission are decidedly at variance with those published under the auspices of Dr. Koch. Dr. Klein, of the English Commission, is not disposed to admit the causative relation of the comma-bacillus, but finds a straight bacillus a more constant element of the choleraic discharges. Further, a report from Calcutta states that Dr. Klein has found in three houses in which the disease was severe that the water-supply was quite pure, while in another locality, in which the water used for drinking and washing was found full of the comma-bacilli, only one case occurred.

The stringent order of the United States Treasury in regard to the importation of rags has had the effect of almost entirely suspending their shipment. Much exception has been taken to the embargo thus established. Dr. George B. Shattuck, of the *Boston Medical and Surgical Journal*, has expressed strongly the opinion that no instance is on record of the communication of cholera by rags or general merchandise, and insists that the baggage and clothing of immigrants are much more likely sources of conveyance of the poison. Dr. Leale, of New York, in an elaborate article detailing his experience in the epidemic of 1866 in that city, traces it to the infection of a car-driver who was seated for a short time on some baggage of steerage-passengers just from a ship. Both Dr. Shattuck and Dr. Leale are of the opinion that the most urgent duty of port-inspection is the examination of immigrants and their baggage. It may, however, be asked, How can this inspection amount to anything more than form? There is no means of distinguishing the presence of cholera and other infection, and if quarantine restrictions are to be applied they will not be successful in excluding cholera if, after the ordinary examination, immigrants are allowed to land with their baggage and be absorbed into any community they may select.

Mr. Ernest Hart, in a lecture delivered in December last before the Parker Museum in London, expressed the opinion most decidedly that quarantine is useless, disinfection of doubtful value, but cleanliness, in the fullest and widest sense of the term, is the prime element of safety. Rome, with its pure water-supply, had escaped; Paris suffered probably in consequence of a temporary supply of highly-polluted water; while Naples owed its losses to a soil impregnated with sewage, filthy habitations, and foul water. Mr. Hart considers the prevalence of typhoid as the best index of the danger from cholera.

In this connection we cannot pass over the recent paper by Rud. Emmerich, of Munich (Pettenkofer's "Archives of Hygiene," vol. ii. part iv.), which embodies the observations made by the author during the recent epidemic in Naples. Dr. Emmerich regards it as absolutely established that cholera is not contagious in the sense that smallpox or yellow fever is, and in support of this view refers to a hospital in Naples, located in the infected district, in which twelve hundred cholera cases were treated and only one attendant took the disease. He regards the general opinion that the disease was distributed by the drinking-water as unsound, and points out that in Naples the virulence of the epidemic did not correspond with any particular water-supply.

METALLIC POISONS IN ARTICLES OF FOOD AND CLOTHING.

Public attention has recently been reattracted to this topic by the elaborate report made by the chemists of the Massachusetts State Board of Health, Lunacy, and Charity. Dr. Edward S. Wood presents a special Report on "Arsenic as a Domestic Poison," detailing the results of the examination of wall paper and glazed papers for kindergarten uses. Quantitative analyses were made in many cases, and slips representing some thirty-six specimens were appended to the report, with a tabulated statement of the analytical results. The quantities vary from half a grain to as much as fifty-six grains to the square yard, the latter quantity having been found in a sample of kindergarten paper.

At the London Hygiene Exhibition one of the exhibits was a drawing representing a cutaneous eruption said to have been caused by a stocking dyed with an aniline color. The exhibit produced much public discussion, especially through the columns of the *London Times*. One enthusiastic

cochineal-dealer asks for the total prohibition of the use of aniline colors. The matter has been taken up by Mr. Levenstein, President of the Manchester Branch of the Society of Chemical Industry, one of the officers of which has shown that it is not demonstrated that the stocking was dyed with an aniline color, and that a cry for a return to natural dyes means nothing of advantage for the public, because cochineal and madder require metallic mordants in their use. Mr. Levenstein says, "Although the question of the poisonous effects of aniline dyes has cropped up from time to time, notwithstanding the most careful investigation it has never been proved in any case that an eruption was due to their use. The only coal-tar color which was found to irritate the skin was an orange color, which is not an aniline dye proper and has long been superseded by harmless naphthol oranges.

"The charge that arsenic is used in the manufacture of aniline dyes is true only of magenta. It appears that even under careless manipulation not more than one-sixteenth of a grain of arsenic can remain in a pair of stockings; and, as this is in a particularly insoluble form, it can hardly be regarded as dangerous."

POISONOUS CANDIES.

About the beginning of the holiday season considerable excitement was created in New York City by the wholesale confiscation of candies under the claim that they were colored by injurious substances. The official statements of the results of the analyses are not at hand, and it is impossible to judge from newspaper reports as to how far public health was at stake. There is no necessity for the use of any poisonous colors in candy. Manufacturers of confectioners' materials now furnish brilliant organic colors free from danger.

LEAD-POISONING FROM WARM-WATER PIPES.

Poisoning by lead in water is so uncommon in Philadelphia that a recent case has some special interest. A baker's family became subject to symptoms which were recognized by the physician, Dr. Berlet, as due to lead, but for a long while he was unable to trace the source. Articles of food were examined without success. Finally the drinking-water was examined, and it was found contaminated with lead derived from contact with lead pipe connected with the hot-water apparatus. It is not unlikely that lead was, in part, in suspension in the water.

ANTISEPTIC PROPERTIES OF CARBON DISULPHIDE.

Carbon disulphide is soluble in water to the extent of from two to three parts per million at ordinary temperatures. This solution can easily be obtained by agitation. Both alone and in aqueous solution the disulphide arrests fermentation, kills microbes, and is one of the most energetic of antiseptics. A solution in alcohol is easily decomposed.

One observer states that during twenty years' experience among workmen continually exposed to the vapor of this substance he never observed any paralysis or loss of virility. When breathed in certain proportions, the vapor produces anæsthetic effects, with an after-effect of headache. When applied to the skin it produces pain like that of scalding, but no ulceration occurs, and the effect ceases when the liquid is volatilized. The substance has been recommended both externally and internally, in spray and aqueous solution, in cases of cholera and typhoid fever.

REGULATION OF THE SALE OF CARBONATED WATERS.

The Board of Health of New York has promulgated the following order as a section of the Sanitary Code:

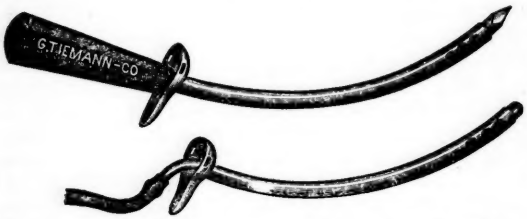
"In the sale of, or keeping for sale, any beverage or drink, no person shall keep or use any tap, faucet, tank, fountain, or vessel, or any pipe or conduit in connection therewith, which shall be composed of or made with brass, lead, copper, or other metal or metallic substance that is or will be affected by liquids so that dangerous, unwholesome, or deleterious compounds are formed therein or thereby, or such that beer, soda-water, syrups, or other liquid, or any other beverage, drink, or flavoring material drawn therefrom, shall be unwholesome, dangerous, or detrimental to health."

This applies elsewhere as well as in New York, and should be adopted by other communities.

DIPHTHERIA.—Chinoline, one of the most actively antiseptic agents at our command, has been utilized as a local application to diphtheritic membrane. It may be used in combination with glycerin. Donath reports very favorable effects from its use upon the local manifestations of the disease.

AN IMPROVED TROCAR AND CANULA.

DR. W. THORNTON PARKER, in connection with the account of a case of impassable stricture of the urethra,* has recently published a description of a form of trocar and canula which possesses some especial advantages. Its construction is readily understood from the cut (kindly furnished by Tiemann & Co.).



Dr. Parker considers it very useful, and superior to any other he has yet been able to find. It can be made in any size, and the curve can be greater, or, if desired, it can be made perfectly straight. The trocar, of course, differs in no respect from those in general use, and the canula is very similar; but after the trocar has been removed, the puncture having been completed, a third piece is introduced into the canula, projecting a little beyond its inner opening to protect the soft parts from being wounded by sharp edges. The lateral openings in the inner canula (which is closed at its end) correspond with the lateral openings in the true canula. The fluid to be evacuated escapes through the inner canula, and is conveyed to a receptacle by a rubber tube. This tube is easily compressed by a spring or common clothes-pin and the flow of the liquid regulated. The person of the patient and the bedclothing are protected from the escaping fluid, and the operation is altogether more satisfactory by using this apparatus. The mouth of the true canula is kept in place by adhesive plaster. It will be readily seen that the dangers of wounding the viscera are reduced to a minimum by this method. The instrument will be found useful for all operations where a trocar is needed, and is in some respects superior to the Fitch's dome trocar.

"THE PHYSICIAN HIMSELF," by Dr. Cathell, will shortly appear in its fourth edition, greatly enlarged and improved.

* Virginia Medical Monthly, December, 1884.

NOTES OF HOSPITAL PRACTICE.

UNIVERSITY HOSPITAL.

CLINIC OF JOHN ASHHURST, JR., M.D.,
Professor of Clinical Surgery in the University of Pennsylvania.

Reported by WILLIAM H. MORRISON, M.D.

FIBRO-LIPOMA OF THE THIGH.

GENTLEMEN,—The first case which I shall show you is rather a surgical curiosity than anything else. This man has an enormous tumor of the thigh, reaching from the knee to the groin. The history is that while serving in the cavalry during the war he received an injury to the thigh, and that the irritation was continued by the pommel of the saddle pressing against the bruised part. A small tumor soon made its appearance, and has been steadily growing for the last fifteen years, until it has now acquired the enormous dimensions which you see. It is a very heavy tumor, as I determine by lifting it with my hands. It is not at all adherent to the bone, and the skin over it is entirely movable. There is, therefore, every reason to believe that it is a non-malignant growth. The history that it has lasted for fifteen years without producing involvement of the constitution points to the same conclusion.

This is probably a fibro-cellular tumor with a considerable development of fat, and might be called a fibro-lipoma. It might possibly be a myxoma, for myxomatous tumors are occasionally met with in the cellular tissue, but I have never known a myxoma to acquire the size which this growth presents. The greater part of this mass is probably composed of fat, with firm interlacing bands, and with hypertrophy of the fibro-cellular and areolar tissue. It is a connective-tissue tumor, and when it occurs as a smaller growth we recognize it as an ordinary wen.

In regard to the question of operation: there could be no difficulty anatomically in removing this tumor. It is superficial, and not attached to the bone. An operation of this magnitude would, of course, cause a certain amount of shock and hemorrhage from smaller vessels. If the operation should be attempted, it would be wise to adopt every precaution for diminishing the bulk of the tumor, as is done in the cases of a somewhat similar character

which are met with in the scrotum, and which constitute one form of elephantiasis of that part. In these cases, which are rare in this country but very common in India, the practice is to have the tumor elevated on a platform and suspended in such a way that the fluids shall drain out of it for several hours before the operation. Some plan of that kind might be adopted in this case. The growth extends so high into the groin that it would be impossible to use the Esmarch apparatus; but the elastic bandage might be applied previous to the operation, to diminish the vascularity of the growth.

The patient does not wish to have any operation performed, but I am glad to have had the opportunity of showing the case to you, for it is one that you will not often see.

EPITHELIOMA OF THE LEG: AMPUTATION.

The next case is one of another form of morbid growth of which you have seen several examples. It is that form of epithelioma which originates in long-standing ulceration. The patient is an adult who received an injury to the leg during the late civil war. I believe that the wound at first healed, but then re-ulcerated, and it has now been a long time since the wound has been closed. While the ulceration has continued, other features have developed, and the granulations have assumed an appearance which we recognize as that of the so-called warty ulcer. Those of you who are near can see that these are not the granulations of ordinary ulceration. There is special exuberance and a decided enlargement in the line of the fibula, and the inference is that there has been implication of the bone in the morbid process.

In a case of this kind nothing short of removal of the limb is of avail. In the early stages something can often be done by the use of ice and dressings of bismuth. The late Mr. Colles, of Dublin, who gave a very good account of this affection, reported several cases in which a cure had been effected in this manner. When the disease is of such long standing and has extended so far as in this case, implicating the bone, there is no advantage in anything short of amputation. This may be done with a good prospect of curing the disease. Of course there is risk to life in an operation of this kind, but if the patient recovers there is not much probability of the disease returning.

There is no form of carcinoma in which the prognosis is more favorable than in this variety of epithelioma originating in old ulcers. This same tendency to the development of cancer in the seat of chronic inflammation is seen in the formation of epithelial cancer of the lip in places where there has been a crack or fissure of long standing.

I shall remove the leg at the junction of the middle and upper thirds. In order to avoid as much as possible the loss of blood, I use the Esmarch apparatus and also a tourniquet. The tourniquet is first applied loosely, and then the limb is rendered bloodless by the rubber bandage and the tube is applied. After the limb is removed, the larger vessels and those which reveal themselves by their pouting mouths are secured, and then the tourniquet is tightened and the tube removed. If the tube alone is employed, there is apt to be free capillary oozing, because the vaso-motor nerves are temporarily paralyzed. By the use of the tourniquet the force of the circulation is kept off until the nerves have had an opportunity to regain their tone and the vessels have again contracted.

In applying the tourniquet to the femoral or other large artery, I usually make a firm pad by folding a bandage on itself several times and apply this over the artery in the line of its axis. This is secured to the limb with two or three turns of the roller, and the remainder of the bandage is laid obliquely on the pad. This prevents slipping, and if the first pad has not been applied directly over the artery the second will secure the vessel.

The operation which I propose to do today is what is termed the external flap operation, which makes the best stump in the upper part of the leg. It is done in this way: an incision four inches long is made along the *inner* border of the tibia; the wound gaping, the tissues are transfixed at the *outer* edge of the bone, and the external flap is cut from within outwards. The internal flap is cut from without inwards, the muscles being cut at the highest point of attachment. The knife is next passed between the bones, and a retractor then introduced and the bones sawed. I endeavor to make the fibula about one-fourth of an inch shorter than the tibia, as I think that this makes a better

stump. In order to do this, the fibula has to be sawn from below upwards. As you see, there is troublesome bleeding from one vessel, which I secure with an acupressure-needle by the second method, passing a needle beneath the vessel and a loop of wire above it and twisting the two together. Where the vessel is retracted this is sometimes the most satisfactory way of controlling the bleeding. The flaps are brought together with silver-wire sutures and supported by adhesive strips. A piece of lint saturated with laudanum is next applied, and over this is placed a piece of oiled silk held in position by a bandage. The leg is elevated on a pillow, and the patient sent to the ward.

In this method of operating, the principal flap is the external one. It is a mistake to suppose that there is no advantage in having muscular tissue in the flap. Although the muscle shrinks until it appears as though the bone were covered only by the skin, the fibrous tissue and the sheath of the muscle remain, and this makes a much firmer envelope for the bone than can be obtained from the skin alone. Wherever it is possible to do so, it is desirable to have muscle over the end of the bone.

AMPUTATION OF THE PENIS FOR CANCER.

The next operation is an amputation of more rarity. This man is 47 years of age, and has had a sore on his penis for nearly two years. This has gradually become worse, and has been followed by great thickening and hardening of the organ. Not only is the glans penis affected, but the greater part of the body of the organ is also involved. Small glands are detected in both groins, but these are not more distinct than is often found in healthy individuals, and there is no reason to suppose that the disease has extended beyond the penis itself. He has been treated in the country, I am sorry to say, for chancre, his physician not recognizing the nature of the case. Had he been operated on at an earlier period, the result would have been more promising; but there is still enough tissue left to make a stump.

Where the penis has to be removed at the pubes, it is probably best done with the écraseur; but where enough tissue is left from which to make a flap, it is, I think, better to use the knife. The skin is divided by a circular incision and dissected back, and the organ cut through, the urethra being left a little longer than the rest. The urethra is then to be split and its mucous membrane attached to the skin of the penis. This is the operation which I shall do in this case.

Although the disease is apt to recur, yet a great deal of comfort is afforded to the patient by the removal of the primary disease, for this is a very unpleasant part of the body in which to have cancer develop. If the disease recurs in the glands of the groin, it is much less painful and much less distressing to the patient. It is, therefore, justifiable to remove the penis for epithelioma even at a late period, and even if the surgeon is satisfied that the disease will recur. I have done the operation even when the glands of the groin were involved, simply with the object of giving the patient the comfort which the operation affords.

TRANSLATIONS.

KIDNEY-DISEASE DEPENDENT UPON EPITHELIOMA UTERI.—In the *Annales des Maladies des Organes Génito-urinaires* a very interesting communication is published by M. Lancereaux, based upon twenty-three cases of epithelioma uteri in which the condition of the kidneys was especially studied. The uterus is the site of three varieties of epithelioma in connection with its three different varieties of epithelium existing in its interior. The most common variety, and the one most frequently associated with renal disease, is cancer of the pavement epithelium. The extension of the disease to the contiguous portion of the bas-fond of the bladder, so often observed, is shown by frequent and painful micturition, possibly by albuminous and bloody urine; and also by general symptoms, such as vomiting, diarrhœa, and loss of appetite. These symptoms are recognized as those of uræmia, and, according to the author, they are so frequent in the course of epithelioma of the neck that their absence is exceptional. Cerebral evidences of uræmia are presented by headache, insomnia, sometimes delirium, often death by coma. Dyspnœa is rare. In all cases there is usually a lowering of bodily temperature of one or two degrees. Evidences of renal insufficiency make their appearance soon after the development of the uterine disease, and often within the first year.

The lesions observed are (1) primitive and (2) secondary. The primitive lesions of the urinary passages are due to the direct extension of the disease from the uterus and vagina and the lymphatic vessels to the bladder and the ureters; they also may be found in some cases in the rectum, the peritoneum, and the nerves of the pelvis. The secondary lesions are those due to extension of the disease from the bladder to the ureters, the pelves, and even the kidneys themselves. Tertiary lesions might be classified as those depending upon the latter disorders. They consist in changes in the digestive tract, and of the heart according to certain authors.

The lesions caused by invasion of the bladder are well known, and need not be repeated. The author describes as follows the effects upon the ureters and kidneys. The ureters involved by the epithelial vegetation, or even compressed and retracted at their termination, retain the urine, which distends them until finally they may be so enlarged in their calibre as to resemble small intestine. The pelves and calices, proportionately enlarged and also more or less distended, may form under the kidneys a collection of fluid as large as an egg (hydronephrosis). The papillary extremities of the Malpighian pyramids are next effaced, and often atrophied. The kidneys, always modified in their structure, present different degrees of alteration, from tumefaction to advanced interstitial nephritis and contracted kidney.

Lancereaux denies that hypertrophy of the heart occurs in these cases of uterine cancer; in twenty-three cases of this secondary nephritis the heart was found to be normal or diminished in twenty; in three the heart was enlarged owing to special causes that were present (dilatation of the aorta or general arterial dilatation).

This contribution directs attention to a subject which has been insufficiently studied, and throws light upon obscure symptoms occurring in the course of malignant disease of the uterus.—*La France Médicale*, February 7, 1885.

Fatal Results after Trephining—Effects of Traumatism upon Cerebral Growths.—A paper, by M. Krimisson, of considerable importance was presented to the Société de Chirurgie at its meeting in Paris, February 4. It was based upon a clinical report of a case of a child who struck its head in falling, without external injury. There was no wound and no loss of consciousness; but in a few moments there was noticed contracture of the jaw-muscles; a week later there was paresis of the left arm and deviation of the face; subsequently the left leg became affected. Six months afterwards there were local headache, vomiting, and muscular contracture. Trephining revealed healthy bone and dura mater. The operation was useless, and death occurred the next day. At the autopsy there was found no evidence of traumatism of bone or encephalon, but deep in the right hemisphere was a tumor as large as an egg, springing from the side of the base. Microscopically, the tumor was found to be tubercular, without bacilli.

The author cited an analogous case of Hulke, whose patient also died after trephining, in which the autopsy showed four yellowish nodules in the cerebral hemisphere. The morbid growth was thought to be independent of the traumatism, because the symptoms appeared too soon after the fall to be more than a coincidence: the fall seemed at the most merely to accelerate the appearance of the symptoms of the cerebral tumor. Two observations by MacEwen were cited to show the effects of traumatism in determining the explosion of serious cerebral disorder within a few hours after the receipt of the injury. A very interesting consideration of the medico-legal aspects of such cases concludes this valuable paper. —*La France Médicale*, February 7, 1885.

Excision of Redundant Scrotum for Varicocele.—The surgical treatment of varicocele by excision of part of the scrotum, which was practised by Sir Astley Cooper, and quite recently by Dr. Henry, of New York, and Dr. Levis, of Philadelphia, has been brought before the French Academy of Medicine by M. Horteloup, who also presented an instrument for the performance of the operation. The curved clamp which M. Horteloup employs is evidently intended to accomplish the same results as Henry's clamp, which the reporter apparently overlooked. To antiseptic precautions principally does the author attribute his successful results, not one of his cases having died, and only three had hemorrhages into the scrotum.—*La France Médicale*, No. 24.

PHILADELPHIA

MEDICAL TIMES.

PHILADELPHIA, MARCH 21, 1885.

EDITORIAL.

IDIOPATHIC ANÆMIA OF ADDISON.

THIS disease, more generally known by the name of progressive pernicious anæmia, applied to it by Biermer in 1871, was first described in 1855 by Addison, in his famous treatise "On the Constitutional and Local Effects of Disease of the Suprarenal Capsules." It was while engaged in the study of this form of anæmia that Addison, to use his own words, "stumbled upon" the discovery of the affection termed by him melasma suprarenale, with which his name will be ever associated. It was the fortunate lot of Addison to stumble upon "no less than four morbid conditions before unrecognized or imperfectly described: xanthelasma, described by himself and Dr. Gull under the name vitiligoidea; keloid, or morphœa, which, as Dr. Fagge has shown, is closely allied to or identical with scleroderma; idiopathic anæmia; and melasma suprarenale."*

Before the publication of Addison's treatise several isolated cases of this fatal form of anæmia were reported, of which the earliest, as shown by Dr. Pye-Smith, is probably that of Drs. Combe and Kellie, which appeared in the Transactions of the Medico-Chirurgical Society of Edinburgh for 1823.

The disease differs from most others in being absolutely devoid of lesions except such as are secondary to the altered condition of the blood. Among these the most prominent are fatty degeneration of the heart, liver, glandular epithelium, especially of the gastric tubules and of the intima of the arteries, hemorrhages in the retina (first described by Biermer) as well as in the corona radiata and on the cerebral surface, sometimes in the form of a hemorrhagic pachymeningitis. In genuine cases of idiopathic anæmia the organs universally recognized as hæmatopoietic—namely, the lympharia, spleen, and bone-marrow—are unaltered. It follows, therefore, either that there are cytogenic organs of the very existence of which we are ignorant, or that in idiopathic anæmia there is an abnormal destruction of red corpuscles. Certain facts favor the latter view. Among them are the deep color of the urine often observed when the red corpuscles are markedly deficient in number, the dark-red color of the muscles, the dark hue of liver, spleen, kidneys, and pancreas, and the unusually yellow color of the subcutaneous fat.

The red corpuscles are often greatly increased in size, varying from four to eleven or even fifteen micro-millimetres, the average in health being eight and a half. "Those of large size were much more numerous than the smaller, and, in consequence, the blood in this disease presents a remarkable and characteristic peculiarity,—namely, that the reduction in the number of the corpuscles is greater than that in the quantity of hæmoglobin; so that the value of the corpuscles is greater than normal. In this respect it differs from all other forms of anæmia, since in these the value of the corpuscles either is unaltered or is below normal."†

Unfortunately for diagnostic purposes, this increased size of the red corpuscles is not constant in idiopathic anæmia; neither is the presence of microcytes, minute red corpuscles, nor altered shape of the red corpuscles, poikilocytosis. The writer has observed both of these peculiarities in a case of anæmia splenica.

* Idiopathic Anæmia of Addison. By Dr. Pye-Smith. Guy's Hospital Reports, 1883.

† Review of Laache on Anæmia in Dublin Jour. Med. Sci., July, 1883.

If, in a case of anæmia, a count of the red corpuscles shows their number to be below one million per cubic millimetre, and the white not absolutely increased, and there is no disease of any tissue or organ of the body, the case is probably one of idiopathic anæmia. If, in addition, many of the red corpuscles are enlarged to such an extent that the average value in hæmoglobin of each, as tested by the hæmochromometer, is as great as or greater than normal, the diagnosis is certain.

The etiology of idiopathic anæmia is quite as obscure as its pathology. The influence of depressing emotion appears, however, to be manifest, especially when it is sudden and violent. This was first pointed out by Wilks, and was illustrated by some remarkable cases reported by Dr. R. G. Curtin at a recent meeting of the Philadelphia County Medical Society. Exception may be taken to Dr. Curtin's cases because in none of them was there an examination of the blood or a necropsy, but clinically they present every evidence of being genuine cases of idiopathic anæmia.

Since arsenic was used in the treatment of this disease by Dr. Byrom Bramwell, the term pernicious has become less appropriate than when first employed by Biermer. A number of recoveries have been reported in which this remedy was exhibited at a late stage of the disorder. Iron, the main stay in the treatment of chlorosis, is of little or no benefit in idiopathic anæmia, and their different behavior towards this remedy constitutes the principal distinguishing mark between the two diseases, which in all other respects are remarkably similar.

THE Transactions of the College of Physicians of Philadelphia will appear regularly hereafter in our pages, in consequence of an arrangement made with the Publication Committee of the College.

ERGOT.

THE fact that preparations of ergot, when administered during labor, do not always yield uniform results has engaged the attention and stimulated the researches of both physicians and clinicians. The attention of investigators has been given especially to the study of the chemistry of ergot to determine, if possible, the principle upon which the activity of the drug depends. Following Dragendorff, the profession regarded sclerotinic acid as the active constituent of ergot, but recently Kobert has, as the result of numerous experiments, reached the conclusion that the active principles of ergot are ergotin acid, sphacelin acid, and cornutin. Of these the ergotin acid seems identical with sclerotinic acid, which Kobert claims has no ecbolic action, and indeed no action whatever upon the uterus. On the other hand, sphacelin acid produces, it is believed, tetanic but not peristaltic contractions of the uterus; it also stimulates the vaso-motor centre, and in toxic doses produces gangrene, ulceration of Peyer's patches, ataxia, and paresis. The third substance, cornutin, is allied chemically with ergotinin, but is strongly poisonous, producing convulsions in animals, and causing a rise in blood-pressure by stimulating the vaso-motor centre without directly affecting the heart. It produces irregular peristaltic contractions of the uterus, but not tonic contraction, and is considered the agent causing convulsive ergotism.

It is difficult to reconcile the statements of different observers with regard to the physiological effects of the constituents of ergot. Possibly the agent of greatest activity is of the nature of a ferment, for it is known that old preparations of ergot are less efficient than recent ones. If such be the case, then the fresh, crude drug, or some recent preparation like the wine or dialysate, made without heat, might, after all, offer the best form for administration.

THE CASE OF GENERAL GRANT.

THE sympathy of the entire nation is with General Grant in his sick-chamber, but, the diagnosis of squamous epithelioma of the fauces and tongue in its early stage having been announced, it does not follow that the distinguished patient is necessarily doomed to speedy death with malignant disease. The physicians in charge of his case are, fortunately, of the highest standing in the profession, and he will undoubtedly receive the full benefit of the extended resources of modern medicine. In the mean time, we hope that frequent and detailed bulletins of the case in medical journals, as well as in the daily press, will be strongly discountenanced by the attending and consulting physicians, for reasons that must be obvious. [Code of Ethics, Sec. 1, Art. I., ¶ 2; also Sec. 2, Art. I., ¶ 3.]

NOTES FROM SPECIAL CORRESPONDENTS.

PARIS.

A YOUNG Philadelphia surgeon has lately received high honors in Belgium. His name is Francis W. Strain, a graduate of Jefferson Medical College and surgeon of one of the steamers of the Red Star Line, "The Nordland." He lately removed a tumor from the face of a lady who is one of the near relatives to the King of Belgium. In recognition of his skill, the young surgeon has been elected a member of the Royal Society of Surgeons of Belgium and has been presented with a royal gold medal which has attached to it a fac-simile of King Leopold's crown.

M. de Lesseps has been writing some of his usual silly letters to the Paris press, giving his ideas of the war in the Soudan (a place he never saw, as he has never been higher up in Egypt than Suez). He made a statement that interests us as physiologists. "The English will never be able to bring the Egyptians under subjection," he says, and gives as a reason that, "by a bizarre caprice of nature, the Fellaheen women can only conceive with Fellaheen men! Never during the works on the canal did a Fellaheen woman have a child by her European consort."

This is rank nonsense. During a residence of two years in Egypt the writer of this letter had some experience with just this sort of marriages, and he noticed in several cases (of which he could readily give the names and position) that, on the contrary, when Fellaheen women are married to Englishmen and other Europeans they become unusually prolific. One had no less than seven children by an English husband.

A most extraordinary suit at law has just occupied the Paris Court of Justice. A M. Bouhyer was the plaintiff, and Prof. Trélat (the great surgeon of the Charity), Dr. Delens, and Dr. Piogey were the defendants. Some time back the patient was admitted to the hospital suffering with infectious lymphangitis, caused by a wound in the thumb from a rusty nail. He was, besides, in a high state of fever, and haunted with the idea that he was being robbed and murdered. The house-surgeon had a good deal of trouble with him, and went to considerable pains to get him well. Prof. Trélat treated him, and after a good deal of trouble brought him around. He got well, and was discharged.

No sooner, however, out of the hospital than he brought an action against all the doctors and surgeons for having practised useless and dangerous operations on him without his consent. He therefore claimed three thousand francs damages. The witnesses brought forward were his fellow-patients at the time, who one and all stated that he had received constant care and devoted attention from all the doctors. Dr. Trélat made a witty defence, saying, "We cannot expect our patients to compel us to exact a duly-certified deed from them before they consent to have their pulses felt, or even a written and signed consent or certificate of their willingness to submit to a lancet-thrust." The doctors defendants, having been put to great trouble and annoyance over the affair, put up a counter-claim of three thousand francs.

The court found for them, *with three thousand francs each*, so that M. Bouhyer will find that his sojourn and treatment in a hospital will entail rather high fees, in all nine thousand francs and the costs. He is the editor of a financial paper. Like many others, he took advantage of the ease with which one can get into a hospital here and have the best advice for nothing.

Dr. Sandras has communicated to the Academy of Medicine a formula which he claims has produced some very remarkable effects on the voice. It is as follows:

Essence of turpentine, 100 grams;
Norway tar, 20 grams;
Chloroform, 1 gram.

Used by inhalation. After its use for a time, it was noticed that the voice became extremely pure and possessed a remarkable volume.

The subject of the depopulation of France has been attracting much attention lately. Prof. Hardy, in speaking of the fact that the

French are not a prolific people, took for example the Paris Faculty of Medicine, which consists of some thirty-four members. Five of them, he said, were single, so he could not speak as to their fecundity. Nine of the remaining had no children at all, although he felt sure they would like to have had them. Of the other twenty, some had one, others two, but only one had a large number (seven); but this exception confirms the rule, as the one in question was of English origin (Prof. Ball). The farther we get from the animal the smaller the number of children. As the French are the nation the highest in civilization, consequently they do not have many children. Q. E. D.

The name of the eminent Professor of Histology, Ch. Robin, is well known in America, as it is in all our works on Physiology. Personally he is not at all popular. In his lectures he presents his already dry subject in a very uninviting manner. This, coupled with the facts that he has gone into politics of late years and was lately elected Senator, and that he is very severe in examinations, has just brought about one of those peculiar "manifestations" of the Paris medical students against him. When he appeared at his usual Monday lecture last week, he was met with a crowded lecture-room (a most unusual thing), and on attempting to start his lecture with the usual "Gentlemen, I said to you in my last," the students shouted, "Resign!" "Resign!" "Go to the Senate!" After several attempts to go on in the midst of an uproar, he was compelled to retire in haste, leaving the students masters of the field. They then quietly withdrew, singing one of their favorite songs. Notice was placed on the board that Prof. Robin would give no more lectures this session, and it is now announced that he will resign.

There was an error in my last letter, speaking of Dr. Debove's treatment of sciatica with *ether*. It should be with *chloride of methyl*, as ether he found to be a failure. The chloride of methyl is sprayed along the course of the nerve, and as the surface gets white the spray is carried to adjoining parts. It is used just long enough to congeal the skin, no second application to be made until the skin has become firm again. Obesity is not a contra-indication, but of course it will take longer to freeze the part and the vesication will be longer healing. Some remarkable successes have been obtained here from its use.

Dr. Tillaux, in opening his clinical lectures at the Hôtel-Dieu, gives some good advice, some of which is aimed at the present medical faculty's method of forcing the students to devote the first year of their studies to botany, physics, and chemistry, their second year to dissection only, and then on the last two sessions they are allowed to frequent the hospitals, which Dr. Tillaux and other teachers outside of the school do not think is right. They feel that it is not needed to study all these different branches and also pathology before commencing to see disease, but that they study their pathology much better by seeing the maladies as they study them. Dr. Tillaux finds that his students will go home at night and study the dryest kind of even rare pathological cases if they see an instance of it first in the hospital. They will even industriously hunt up for him all the authorities and cases of the malady in the great medical reading-rooms of Paris. Diagnosis, he thinks, should be taught by *deduction*. It was in this way that Nélaton taught. When Dr. Tillaux was Nélaton's interne, he gave him a precept that has never been published. It was this: "When, in the examination of a patient, you notice a symptom that does not accord with the other symptoms, attach yourself to it. Don't neglect it, and it will very often lead you to a correct diagnosis." Dr. Tillaux spoke very highly of the mode of dressing wounds, called Guérin's system, now so much used in all the Paris hospitals, which consists in completely covering all wounds and all open sores with a thick wad of antiseptic cotton, designed to filter the air and arrest on their passage the famous microbes and all other ferments of purulent infection.

Sulphate of Cinchonamine.—This cinchonamine comes from the *Remigia*, of which the bark has often been used to adulterate the real cinchona bark. Prof. G. Sée has been studying the action of this bark on various animals. The results from his experiments so far show that the sulphate of cinchonamine acts in a most remarkable manner on the heart. It slows its movement and diminishes the vascular pressure, then finishes by stopping the heart in diastole, thus differing from every other heart-remedy. It will soon be tried in various heart-troubles, and we will report results.

Dr. Després, at Charity Hospital, remarking upon a case of polypus before operating, said, "These polypi are often divided into those inside and those outside the uterine cavity. Some surgeons are in favor of waiting until they protrude partly, and others advise to operate at once. I am rather in favor of waiting as long as possible, as I do not like to dilate the uterine cervix, which, as it was formerly done, was really a rather dangerous proceeding, though now it is much less so, as the former sponge tents prepared with wax are almost abandoned for the tents made of laminaria, which leave an open space in the middle to permit any liquids to drain away. The polypus will eventually dilate the organ itself if allowed to do so; so that, as a rule, there is no need of haste unless the hemorrhage become very great. I

do not approve of the use of ergotin, as it will only contract the cervix more. When the hemorrhage is slight, it can almost always be controlled by the administration of strong black coffee. This may be given every fifteen minutes in half-cup doses up to five of them. It may give rise to some excitement and even slight palpitations, but this can be disregarded if the hemorrhage is relieved.

"As to the operation, the most simple means is the best, but the usual plan of seizing the tumor with the long volsella forceps is not the best plan by any means. Attempts at torsion and traction, when severe, often require the repetition of the whole performance over again under most disadvantageous circumstances. All lengthy manipulations carried on *in utero* are dangerous. I place the patient on her *right side*, and make use of an American speculum (Sims'), which allows me to see what I am doing. Upon introducing the finger I feel that the polypus is partly out, and one would think that I had only to drag it out at once, but I will not attempt to do so. I have here a little hook which is smaller than my finger (it is used for vesico-vaginal fistulas). This I hook carefully into the polypus, which I find gives way readily, but I do not make traction. I now introduce, sliding it carefully up along the little hook, the 'wire-rope écraseur,' stopping whenever I find any resistance. It is now about six centimetres in above the cervix, which indicates to me that I am near the uterine walls. I now make steady traction and screw tightly, cutting the pedicle, thus bringing away all the polypus and terminating the operation."

The patient, put to bed, was treated with this injection:

Chloride of zinc, 5 grams;
Aqua pura, 500 grams. M.
Fiat sol.

This was used for the first day only. Afterwards she had six injections of warm water daily, and left the hospital cured in two weeks. It may be stated that this polypus was an *intermittent one*, as on resting in bed it would disappear within the cervix, which would close on it and all discharge cease, but on resuming active employment it would again begin to give trouble.

The American drug *Rhamnus Purshiana* (*Cascara sagrada*, as it is often called) has lately been the subject of considerable investigation in France. Prof. Grasset, of the Montpellier faculty, and others have made a series of experiments with it, with the result that while they do not entirely confirm the opinion of Dr. Emeri that it is a specific for *all* cases of habitual constipation, still they find that it is a most valuable laxative, and assert that certainly there does not exist a remedy that is as efficacious in the treatment of chronic constipation. It is given here in *cachets* containing twenty-five centigrammes of the bark in powder. One is often enough, but two or three are given when needed. It produces in five hours stools that are nearly always consistent. It is claimed also that it will influence the menstrual function.

Prof. Trélat made some remarks upon malignant growths in the mammary glands, which, if not quite new, still embody important truths. He presented a case at his clinic recently of a woman about 41 years of age. She stated that four months before she had noticed a small tumor just under the skin, and quite mobile, at first painless, but within the past two months she had noticed from time to time lancinating pains, particularly at the monthly period. The tumor was still somewhat movable, but was about contracting adhesions to the skin, and an exploration of the axillary space showed a ganglionic chain extending to the breast, like a small, hard cord.

Prof. Trélat remarked, "We are here in face of an inexorable affection for which medicine can do absolutely nothing. What ought we to do? I said that four-fifths of them have a relapse after operation. Well, that is already a notable improvement over that of medicine, which lets them all die! and now, with our new, improved system of surgery, we can show that our mortality-rate from these operations is only three to five per cent. To come at once to the point: in these tumors it is our duty *to operate*, for three convincing reasons: 1. Because the operation of itself only gives rise to a very small mortality. 2. Because the patients are reasonably sure to live much longer than those not operated upon. 3. Because a certain number of them will be cured by the operation. Cure is possible, then, but how? You must *always take off the whole of the gland*. If it adhere to the aponeurosis, take that off also, even if you take along some of the fibres of the pectoralis major. Then at the slightest suspicion of the ganglia being involved, even if you are not certain of it, empty the whole of the axillary space. In fact, cure will depend on a strict observance of these three rules: *Early diagnosis; prompt operation; complete ablation*. By this means you can at least be reasonably sure of giving the patient prolonged existence, which no other mode of operation will do."

Dr. Debove, at a recent meeting of a medical society, said "that the existence of a hysteric form of fever had been denied by most authors, but that he had observed a certain number of facts that seemed to plead in favor of a contrary opinion. As a rule, when fever is observed in hysterical patients it often is suggested that there is latent tuberculosis which is not appreciable, as the physical signs have not yet been noticed; but this hypothesis cannot be admitted when we have followed a patient for several years and find no signs of phthisis.

"I have attended a young lady for five years, who is now about 24 years of age. She has suffered from hysteria from the age of seven, with all its usual attendants of contracture, paralysis, etc., but outside of these attacks she is quite sensible, and even a very reasonable person. Three years ago she had for the first time an attack of fever, which was characterized by the usual three stages of cold, heat, and sweat. A careful examination furnished not the slightest information as to the cause of the fever. Since then her temperature has been taken regularly every day, and the temperature has never gone lower than 38° (about 100° Fahr.), and it has often gone higher.

"At first I attributed these fever-attacks to malaria, as she had formerly lived in a district in Italy where fever was endemic. I supposed that the *intoxication paludéenne* was the cause, but I was forced to abandon that idea because sulphate of quinine had no effect, and she did not present any other sign of the cachexia. I had also supposed that it might be a tuberculosis which I would see in all its evolutions. I do not need to say that in this case the patient was not one in whom any simulation could be suspected. During one of these attacks, which lasted two weeks, the thermometer oscillated between 40° and 41° C., and the pulse beat 120 to 130 times a minute. There was also cephalalgia. I prescribed antipyrine, and the fever fell at once. However, I do not wish to conclude that this substance was the cause of the cessation of the fever. In presence of these facts, it seems difficult not to admit that there exists in this case real *hysteric fever*. I have before observed such cases, but not long enough to draw conclusions, but the present case is one that has been now for such a long time under observation that I am disposed to admit the existence of such a fever. I cannot see any reason why it should not exist. There is nothing in physiology or pathology to prevent it. Indeed, the very conditions that act on the thermal centres are met with in the hysterical state.

"I also tried to reproduce hysterical fever by suggestion, and made experiments on several subjects of both sexes. I obtained in most of the cases an elevation of temperature that varied from 0.5° to 1.5°. I tried to reproduce also a chill in the same subjects by suggestion, but the results were contradictory. Nevertheless, these experiments should stand as a new argument in favor of hysteric fever."

The following formula is used in hæmatemesis in Paris hospitals:

℞ Acetate of lead, .025 gram;
Opium in powder, .05 gram;
Pulverized sugar, .50 gram. M.

Divide in ten powders, and take one every half-hour.

Dr. Straus, speaking at the meeting of the Medical Society on the non-transmissibility of tuberculosis by vaccine matter, said, "The discovery of the parasite of tuberculosis has brought again to the attention of observers the possibility of the transmission of tuberculose by vaccination. M. Toussaint some years ago vaccinated, with some vaccine matter from a phthisical cow, two animals, which became affected with the disease. This discovery did not stop there, for Dr. Koch's experiments have given renewed interest to these researches. Meyer, of Berlin, revaccinated all the phthisical patients in his service at the hospital. Four of them presented vesicles that were very clear, and their contents were examined by the microscope, but without any results. I have made the same experiments, and the revaccination has succeeded on five of my patients. I spread a part of the contents of the pustules on plates and tried by Ehrlich's method to find the bacilli, but I could not find any. I proceeded at the same time to inoculate another part of the contents of the pustules into the anterior chamber of the eye in several rabbits, but they never became tuberculous. M. Chauveau has just given the Medical Conference at Copenhagen the same results after some experiments of his, and M. Josserand has published at Lyons the results of his efforts, which had the same ending. On summing up these facts, we have some twenty-odd negative experiments of the transmissibility of tuberculosis by vaccine matter under these conditions, and, notwithstanding the cases of M. Toussaint, it seems to me that his experiments lose their value. In any case they are not sufficient to prove that tuberculosis is transmissible during the operation of vaccination under ordinary circumstances. The vaccine used was tried on children mostly, and it is known that they present, by reason of their age, an almost complete immunity from phthisis. Therefore, if we cannot transmit the disease by taking the matter from old phthisical patients, this transmissibility would be even less likely to occur if the vaccinifer were a child. It is, besides, very difficult to inoculate tuberculosis by simply scratching the skin. In order to succeed, the matter has to be injected into the subcutaneous cellular tissue."

Dr. Dujardin-Beaumetz had occasion lately to try the method of treatment of pseudo-membranous bronchitis by a mixture of tar and essence of turpentine in the case of a child 4 years of age, which had an attack of suffocation which left but little hope of saving her. He ordered them to burn in the room a mixture of coal-tar and essence of turpentine. The next day he saw that, following an attack of vomiting, she had thrown up false membranes tubular in shape and black in color. The child rapidly improved and got well. He thinks that the black color proves that the vapors of the mixture really penetrated into the respiratory tract. He does

not believe that they dissolve the membrane, but that they prevent their reproduction. In any case, these vapors are inoffensive. They have only the inconvenience of making everything black in the room, as well as the persons who attend the patient. Some very good results have already been reported from this method of treatment.

For the past year experiments have been going on to meet the demand for a better stethoscope, more adapted to the wants of the student and general practitioner. With the very best so far invented it was felt that only the skilled specialist could be sure of the exact sound he heard. All our modern stethoscopes are at best but acoustic tubes which can only transmit a sound by the column of air that is within them. It is well known that all such transmitted sounds are attenuated. The want, then, was something to augment the sound in place of diminishing it. Starting from that idea, the present stethoscope was invented. The principal part of it is called the *phonogène*, and it is formed of a membrane or a sort of tympanum stretched over the top of a metallic sounding-board or disk, as in a telephone. It is then placed in a hard-rubber receiver, and an ear-piece is attached to it, which is a simple flexible rubber tube and ear-piece (for one ear only). The whole thing is very light. It could be concealed in one hand with the rubber tubing rolled around it.

The sounds given by it are increased, that is, they are sufficiently augmented to be quite distinct, and they are very clear and distinct *without changing the pitch*. A final advantage is its moderate price, three dollars. There are two kinds made. One, made for heart-sounds only, augments the sounds more than the plainer kind used for general auscultation.

There has been quite a revival of the galvano-thermo-cautery in Paris. In the hospitals there is hardly a clinic that passes but that one of the forms are used. Great improvements have been made in them, and they are now constructed in every shape and form, and used for every ill in the world almost. An example of the rage for its use was shown the other day at a clinic, when Prof. Richet burnt quite a little hole in a boy's chin who had an abscess that manifestly came from a bad tooth. But great surgeons are not supposed to know anything about the teeth, and he certainly cured the abscess, even if it did leave a scar. These cauteries are then in constant use for ablations of tumors of the uterus, the tongue, on the eye, and even fistula in ano is now burnt with them. Dr. Péan says he prefers them to a knife ; and he is one of those surgeons who would cut anything when he can. He makes with great success at least one, and often two, ovariotomies every week. While speaking of this, it may be said that these operations are almost never performed at the hospital. Dr. Péan insists on the patients having the operation done at their own houses, be they ever so poor. He prefers that to the hospital, and this is probably one of the reasons for his great success in the operation.

Dr. Besnier, of the St.-Louis Hospital, has made some remarkable cures of lupus of the face with scarifications made with a special form of cautery. Some of them are fork-shaped (like a flat, six-pronged fork), which produces long, profound scars. Others are made to produce points, some single and others from four to eight points, about the size of a pea.

Dr. Desarenes uses a cautery that opens out like a fan in three sections when introduced in the nose or pharynx. He also has others in bulb shape and in flat blades. With them he has had great success in the treatment of chronic catarrhs of the naso-pharyngeal space (post-nasal catarrh). He has lately published a pamphlet on their uses.

A New Apparatus for inducing Anæsthesia.—From a careful observation at the great surgical clinics of Professors Verneuil, Trélat, Tillaux, and others, in regard to the means used for anæsthesia, it is observed to be *always chloroform*. (It is taught here that ether is dangerous from its *inflammable* and *explosive* qualities.) They very often have trouble with their patients, who, when they do not, at least all have a very dark, cyanosed appearance, and they are almost always obliged to use tongue-forceps or even adopt other means to keep the respiration going.

On the contrary, at Dr. Péan's clinic, where he always does some very important operations and a large number, say ten to a dozen, of smaller operations, the patients all sleep quietly, and there is not the slightest discoloration of the face. There is rarely any excited stage, even with drunkards and nervous women, and never any trouble of any kind. Yet it is chloroform, but given according to Prof. Paul Bert's method with a machine invented by Dr. Dubois. This machine gives accurate doses of chloroform and air. It is not new, of course, to give measured doses of chloroform and air. This was attempted some years ago in Boston with some sort of gauged bottles, and other methods have been tried similar to the gasometers of the dentists with nitrous oxide, but none of them have established a real mathematical dose so well as this machine that Dr. Péan has now been using over a year. It has been tried in over three hundred cases with entire success. It consists of a small tank about two feet high and wide, that can be placed on a table. The air can be taken into it from the outside, as it is done at the St.-Louis Hospital. The chloroform is measured into it at regular intervals by the aid of small tubes (hollow) that take it up from a wide-mouthed bottle, into which

they pass by a small chain-movement like the old chain-pumps. This is turned by the hand or may be attended by an assistant. The definite admixture of chloroform and air is applied to the face by a mouth-piece like that used for nitrous oxide. There is also a nose-piece, by which the anæsthetic action is kept up during operations on the mouth and palate, etc.

Several tubes, marked with the quantity to be used to each one hundred litres of air, go with each machine. Eight per cent. is the usual proportion used, but more often they commence at eight, then raise it to ten, and then lower again to eight or six. The patients go under it quietly, and are often kept under it an hour. In two hundred cases it varied from ten minutes to eighty minutes: the last was the longest. The worst of the machine is that it costs ninety dollars. This week, however, they have made the first large lot of them, the first being experiments that have been in use now over a year, but with such success that some hundreds have been ordered. THOMAS LINN.

CINCINNATI.

THE Commencement exercises of our three regular medical colleges have all taken place. The Cincinnati College came first, and graduated a class of twenty-five; the Medical College of Ohio followed, with a class of fifty-nine; and last evening the Miami presented diplomas to twenty-seven newly-fledged "doctors."

Prof. Whittaker made a very felicitous valedictory address at the Ohio Medical College commencement. He contrasted the practice of medicine in early times with that of to-day. Then the physician relied on superstition, ignorance, and experience. Now superstition has given way to scepticism, ignorance to knowledge, and experience to experiment. He cited the former fearful ravages of the plague and the futile endeavors to stay it by incantations, then he spoke of the present scientific investigations into the origin of cholera. As a result of modern experimental research he mentioned Koch's discovery of the tubercle-bacillus, and the effect it was likely to have on the prophylaxis of phthisis pulmonalis.

Prof. Langdon, of the Miami College, took for his valedictory theme "Germs," which subject he treated in such a happy manner as to interest both the faculty and the laity. Prof. Langdon has just completed his first year as anatomical lecturer in the college, and has proved a drawing card. While the number of graduates this year is much less than last, the outlook for the coming year is already better.

During the past winter Cincinnati has been visited with an especially grave epidemic of measles. In some instances every child in the family would die in rapid succession, no remedies seeming to influence the course of the disease. The fatal termination has generally been brought about by the supervention of catarrhal pneumonia. Indeed, primary pneumonia has also been unusually fatal and frequent. Two of our prominent physicians, Drs. William Carson and William Clendennin, are now lying very low with this disease. They are among our oldest and best physicians, and have been prominent in college and hospital circles.

At the recent election in the Academy of Medicine, Prof. Samuel Nickles was chosen president. He has filled the chair of Materia Medica in the Medical College of Ohio since Roberts Bartholow was transferred to the chair of Practice. Prof. Nickles is becoming noted for his accurate knowledge of any subject pertaining to medical drugs, in which department he is the acknowledged authority in the Academy. He is an unassuming yet forcible speaker, and possesses the entire respect of the members.

At the last meeting of the Academy Dr. Whittaker reported a case in which obstruction of the bowel had been much benefited by washing out the stomach. Five years ago he reported a like case, the first recorded. Since then it has been practised with curative and palliative effect in this country, and especially in Germany. Dr. Ransohof was inclined to think that it might answer where there was not much the matter, but that the surgeon's knife was the proper way to relieve serious obstruction, and that there should not be too long delay in its use. A. B. T.

MARCH 11, 1885.

PROCEEDINGS OF SOCIETIES.

COLLEGE OF PHYSICIANS OF PHILADELPHIA.

A STATED meeting was held January 7, 1885, the President, Dr. J. M. DA COSTA, in the chair.

Dr. WILLIAM PEPPER presented the specimens from

A CASE OF ADDISON'S DISEASE.

(See page 454).

DISCUSSION.

Dr. FREDERICK P. HENRY remarked that this was undoubtedly a genuine case of Addison's disease, and remarkably free from the frequent complications of that affection. The rarity of Addison's disease in this country may be judged of by the fact that in the eleven volumes of the Transactions of the Pathological Society of Philadelphia there are reports of only two cases, and these were made by Dr. Henry, in whose practice they occurred. They are to be found in vols. v. and x. The specimens from one of the cases are now in the museum of the Episcopal

Hospital. Dr. Hughes's report upon the condition of the blood in this case is very interesting. Most writers upon Addison's disease are accustomed to attribute the profound adynamia so characteristic of the affection to a high degree of general anæmia, in spite of the absence of any facts to support such a theory. This adynamia is due to an insufficient supply of blood, although of good quality, to the supra-diaphragmatic portion of the body, the result of an accumulation of blood in the abdominal blood-vessels caused by vaso-motor paralysis. Free pigment in the blood has only been once before observed, so far as the speaker is aware, by Van den Corput (*Gaz. Hebdomadaire*, 24 Juillet, 1863). The changes observed in the sympathetic ganglia are of undoubted interest, but it must not be forgotten that typical cases of Addison's disease have been observed without perceptible lesion of these ganglia. Eulenberg and Guttmann (*Journal of Mental Science*, January, 1879) have collected twenty cases in which changes were found in the nerves of the supra-renal plexus and the ganglia of the solar plexus, opposed to which they place twelve cases in which careful examination demonstrated no change whatever. The positive observations included fatty degeneration (found by Queckett in one of Addison's original cases), swelling and redness of the nerves of the lesser splanchnic and ganglia of the solar plexus, atrophy, pigmentation of the ganglionic cells, increase of connective tissue in the ganglia and in the neurilemma of the nerve-fibres, and caseation of the semilunar ganglia.

Primary affection of the abdominal sympathetic has been appealed to as a cause of numerous other affections, notably of Bright's disease, by Drs. Da Costa and Longstreth, on the basis of careful microscopic examination of the ganglia in nine cases (*Am. Jour. Med. Sci.*, July, 1880). The accuracy of their description of the condition of the ganglia has been confirmed by Dr. Robert Saundby (*Brit. Med. Jour.*, January 13, 1883), whose observation has been still more extensive (fifteen cases), but he entirely dissents from their conclusion as to the primary nature of the sympathetic affection, and points out that similar changes have been found in the ganglia in diffuse eczema, pseudo-hypertrophic muscular paralysis, pernicious anæmia, glio-sarcoma of the brain, general paralysis of the insane, cholera, and diabetes. He points out in conclusion that Giovanni (*Patologia di Simpatica*, Milan, 1876) "found cellular infiltration of the sympathetic ganglia in an immense variety of visceral and general diseases, showing that structural changes in the organs are very generally accompanied by signs of irritation in the ganglia."

It is not necessary, however, that there should be a destructive lesion of the solar plexus and semilunar ganglia in order to produce vaso-motor paralysis of the abdominal vessels. Irritation of a sensory nerve produces vaso-motor paralysis in the irritated region, and the well-known experiments of Goltz (*Klopfversuch*) have shown that irritation of the intestines produces complete vaso-motor paralysis of their blood-vessels, causing thereby so great an accumulation of blood that the animal shows symptoms of syncope, the same as if it had been bled copiously. In Addison's disease, from the beginning of the morbid deposit in the medullary substance of the supra-renal capsule, an irritation is transmitted to the semilunar ganglia and solar plexus, by which means a vaso-motor paralysis of the abdominal vessels is produced, as in the experiments of Goltz. This constant hyperæmia leads to enlargement of the glands of Brunner, the solitary glands, and Peyer's patches, so constantly met with, and, when more intense, to catarrh and ulceration of the intestinal mucous membrane. It also accounts for the dark color of the liver, spleen, kidneys, and pancreas so often observed, as well as for the brown color of the peritoneum sometimes noted, notably in a case of Severini. Indirectly it explains the anæmic and dry condition of other parts of the body, and fully accounts for the symptoms of muscular weakness, syncope, and gastro-intestinal disturbance.

In the case under discussion no mention is made of the size of the heart, which is noted as being small in numerous autopsies and the seat of fatty degeneration in several. On account of the abdominal hyperæmia, the quantity of blood reaching the heart at each diastole is less than under normal circumstances, and thus the invariable weakness, smallness, and softness of the pulse are explained. The heart is never normally distended, and thus its cavity becomes permanently diminished. On account of these heart-changes the abnormal distribution of the blood due to the abdominal hyperæmia is still further facilitated. Anæmia of the central nervous organs explains the dizziness, tendency to somnolence, lassitude, and lowness of spirits so often observed; also attacks of prolonged prostration and loss of consciousness, with convulsions; sometimes a condition of collapse that has been compared by Wilks to that of cholera. All the nervous symptoms of Addison's disease are not, however, to be explained by the theory of cerebral anæmia: such, for example, as restlessness, sleeplessness, psychical disturbances, clonic spasms in various muscle-groups, and sensory and motor paralyses. In such cases there is probably irritation of a cerebro-spinal vaso-motor centre, causing local hyperæmias of the central nervous organs. There are two paths by which such a reflex action may travel: 1, through the cœliac axis and its connection with the medulla spinalis; 2, through the branches of the phrenic and pneumogastric distributed to the supra-renal capsules; and

the degree of this irritability probably varies in each individual.

In connection with the abnormal deposit in the skin in Addison's disease, certain observations of Thudichum are of great interest. For sixty-five consecutive days he examined the urine of a patient of Dr. Burdon Sanderson. Without complicating fever or diarrhœa, there was a great diminution in the daily amount of urine excreted: the sp. gr. was 1020 and upwards, and the reaction acid. The observations were chiefly directed towards the determination of the percentage of uromelanin, omicholin, and uropittin, three products of decomposition of urine-pigment, of which the first is the most important. It has almost the same chemical composition as the melanin of the choroid and of the melanotic tumors, and, like the pigment in the skin, is iron-free. Thudichum found these pigments greatly reduced in amount, the uromelanin never rising above one-twelfth the normal. The speaker has been unable to find any record of a spectroscopic examination of the pigment deposited in the skin in Addison's disease, and would suggest the importance of such examination being made. There is an iron-free product of decomposition of hæmoglobin, namely, hæmatoporphyrin, which is iron-free hæmatin, the absorption-bands of which are figured in Hermann's "Handbuch der Physiologie," Band IV., Theil I. It would be interesting to compare the absorption-bands of these two iron-free pigments, both of which have their origin in the coloring-matter of the blood. It is evident that the diminution in the amount of urine-pigment may be in relation to the excess of pigment in the skin. The observations of Thudichum await further confirmation.

REPORT OF A CASE OF FOREIGN BODY IN THE PHARYNX: DEATH RESULTING FROM FAILURE TO RECOGNIZE ITS PRESENCE AND TO REMOVE IT IN TIME. BY WALTER F. ATLEE, M.D.

It is not at all an uncommon occurrence to have a visit from a patient who complains of having swallowed something that is still sticking in the throat. In almost every one of these cases there is no foreign body in the passage. Those patients have a local pain, in some cases the result of injury by a hard body hurriedly swallowed, and they are so entirely convinced by this sensation that a foreign body has lodged there that it is impossible to make them believe otherwise. The surgeon himself may make a mistake, and think he feels a something that ought not to be there. I heard even Nélaton say that in a certain case, after pushing his finger deeply into the pharynx and feeling a small resisting body, he made several attempts to seize it with the forceps before discovering it to be the great horn of the hyoid bone.*

* See Clinical Lectures on Surgery, by M. Nélaton, p. 54.

I made observations somewhat similar to these to a man who came, in great excitement, on the evening of the 30th of last December, to take me to consult with a well-known and experienced physician in the northern part of the city in the case of a child in a dying condition from the presence in the throat of a pin, as the father protested, but which the doctor had not found and did not believe to be there. On the afternoon of Christmas-day, five days before, the father said his child, just seventeen months old, most certainly had a pin in her mouth, that it had disappeared when he went to take it out, and the symptoms of throat-trouble began at that time. For five days the child had taken food with great difficulty and reluctance, keeping the hands in the mouth as if striving to pull something from the throat.

It will here be called to mind that while more bulky objects generally become arrested at the junction of the pharynx with the œsophagus, where the tube is narrowest and least easily expansible, a thin and pointed body, such as a pin, generally sticks between one of the pillars of the fauces and the tonsil, or thereabouts. Again, when such a body stops in the pharynx, that which takes place is owing less to its size than to its shape: it is a body that, as a rule, cannot be pushed farther instead of being extracted, as is often done with bodies of another kind. *It must always be extracted.*

On reaching the house, the child was found lying in a cradle, on her left side, the head thrown back, in a state of stupor, from which she could be roused but very imperfectly. She had had during the day several convulsions. The lips were bluish, and the whole countenance extremely pale, with a bluish tinge. There was a swelling in the neck on the right side, which was the uppermost, below the mastoid process, posterior to the line of the ear. This swelling was not so hard as in cases of diphtheria: it had the feel of cellular tissue affected by acute œdema and not by phlegmonous inflammation. In the mouth was some ropy mucus tinged with blood, but there was no repulsive odor. While examining these appearance it was suggested that the child had the mumps. There was no swelling, however, about the temporo-maxillary articulation, nor anywhere anterior to the ear. It was posterior to the ear and inferior to the mastoid process. Moving the head, the left side of the neck presented a condition similar to that on the right, though not so marked.

The attending physician said his treatment had consisted mainly in the administration of the chlorate of potassa in a syrupy solution. He did not believe in there being any foreign body in the child's throat, but was very willing to have search again made for it. When searching for it himself, he had made use of his eyesight only, and had never passed his fingers into the pharynx.

The child was taken up and held in the nurse's lap in a convenient position for the examination of the pharynx. The doing of this roused her somewhat, so that a few drops of chloroform were used to quiet her. The mouth was then opened, and the jaws kept apart by a large cork. When the finger was passed into the throat a pin was encountered, firmly fixed there, and seemingly stuck, one end between the right tonsil and the pillars of the fauces and the other in the posterior wall of the pharynx. The extremity of the forefinger of the left hand being kept in contact with the pin as a guide, a dressing forceps was made use of; and on the second attempt to seize it, and with the use of some force and some manœuvring to dislodge it, the pin was withdrawn. The pin was exactly an inch and three-sixteenths in length, and it was bent in the centre at an angle of about a hundred and twenty degrees. This bending could scarcely have been produced by the force used in extracting it from the throat.

As there was, of course, great difficulty, even impossibility, in making the movements of deglutition, and every attempt to swallow must excite reflex movements in the pharynx and retard cure, it was advised that no food or medicine should be given by the mouth. In order to try to nourish and stimulate the patient, appropriate enemata were ordered. The child, however, never revived, the stupor became more and more profound, and she died the following day,—just twenty-four hours after the removal of the pin. The cause of the trouble, the source of the irritation, having been gotten rid of, hopes were entertained that the patient might recover; but, as is often the case in children when the exhaustion and the enfeeblement of the nerve-centres have been so great that repeated convulsions are the result, she never again became conscious, and life gradually went out.

The history of this case teaches nothing new, but it is well at times to be reminded of what may occur, and of the extreme care and watchfulness that are at all times demanded in the practice of our profession, in order to avoid sad and even fatal mistakes.

Nearly a century and a half ago, it was in 1743, Hevin wrote, in the first volume of the *Mèmoires de l'Acadèmie royale de Chirurgie*, his *Prècis d'observations sur les corps ètrangers arrêtés dans l'œsophage*. In this paper, a hundred and sixty pages in length, by the recital of the facts themselves, by a long series of all the cases that had been until then recorded in ancient and modern times, are set forth the diversity of effects produced in the pharyngo-œsophagean canal by not only bodies of different kinds, but also by those of the same shape and nature, the different success of the means employed, the dangers more or less urgent to which the patients are subjected by the presence of these foreign bodies, and the consequences to be dreaded when they fall into the stomach.

About fifty years ago, Mondière, in the *Archives de Mèdecine*, wrote a number of "Memoirs,"* in which he says that although all the means for fulfilling the various indications that can be called for are all in this paper of Hevin, yet it does not set forth as precisely as should be the dangers that may result in cases of this kind from leaving too much to nature. His object in writing, he adds, will be successfully attained if he succeeds in warning young practitioners against a security to which they cannot always trust without regret, and he gives cases of spasm, convulsions, suffocation, inflammation, scirrhus, abscess, and saccular dilatation of the œsophagus, the result of failure to remove a foreign body arrested in the canal.

It is with this object—namely, that "of warning against a security that cannot be always trusted to without regret"—that I have ventured to take up the time of the College this evening with reading the history of the foregoing case. "*Bene facit qui ex aliorum erroribus sibi exemplum sumit.*"

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING, THURSDAY, FEBRUARY 5, 1885.

The President, B. F. BAER, M.D., in the chair.

CERVICAL PREGNANCY.

DR. E. E. MONTGOMERY read a paper in which he recounted the history of a case seen by him in consultation with Dr. Alexander. The patient had been pregnant eight times: the last labor had been terminated by forceps. The present pregnancy had lasted three months when she was taken with severe pain and quite profuse hemorrhage. An examination under ether disclosed that the cervix was distended, forming a globular tumor. The os, turned backward, was filled up with a tense membrane; breaking through it, the cervix was found to be a large cavity in which were the fœtus and its envelopes. The body of the uterus appeared like an excrescence upon the distended cervix: it would admit a finger, and was lined by a decidua. The membrane below was continuous with the outer mucous membrane of the cervix, so that the remains of it hung as a fringe from the os.

This case differed from the few cases of this condition described, in that there was no contraction of the os: in the majority of cases it occurs in primiparæ, and when discovered it is necessary to proceed to operative measures to make an opening.

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* For Mondière's "Memoirs" see the Archives Générales, vols. xxiv., xxv, xxvii., and xxx. of the first series, and vols. i., ii., and iii. of the second series.

Dr. GOODELL remarked that he had no knowledge of cervical pregnancy. One case which had been sent to him as such was epithelial cancer of the cervix. How could such a case be diagnosticated without a post-mortem examination? Dr. Montgomery's hypothesis of an arrested abortion was probably the correct solution of such a case as he had described. The fœtus might be forced out of the body of the uterus and arrested in the cervix by an unyielding os or by cicatricial bands. Some years ago, a physician of this city, of large obstetrical practice, had borrowed his écraseur for the removal of a supposed uterine polypus, which proved to be a fœtus in its amniotic sac. Dr. Goodell had never been able to understand how an experienced man could make such a mistake, but the description of this case of cervical pregnancy has thrown light upon the matter. Dr. Montgomery's description of the distended cervix would apply very well to uterine polypus with a long pedicle, and a mistake in diagnosis might easily be made.

Dr. MONTGOMERY questioned the primary occurrence of cervical pregnancy. He believed the fœtus had originally taken its seat in the body of the uterus, and was forced into its lower position later; but it might have been primary; the internal os being patulous, the same conditions that sometimes cause placenta prævia might cause the entire fecundated ovum to be arrested in the cervix.

RUPTURED UTERUS.

Dr. B. F. BAER presented the specimens and related the history (which will be found in full in the *American Journal of Obstetrics*). Mrs. F., colored, 32 years of age, married ten years, had borne four children at term and had one miscarriage. The first child was forceps-delivered and was still-born. November 14, 1884, she was taken in labor, a midwife being in attendance who pronounced everything correct. After a few hours of severe pains, the patient "felt something break in the womb," and labor ceased, but was replaced with sharp pains all over the abdomen; blood escaped in great quantity from the vagina. Collapse ensued, and she was thought to be dead. A slow reaction occurred, and her attendants waited for labor to begin again. Dr. Fisher was called to see her ten days after the accident. He found her abdomen tender and tympanitic; a mass like the head of a fœtus in the right hypochondriac region. The pelvis was empty. Temperature 103°; pulse 108, and small. Rupture of the uterus and escape of the fœtus into the abdominal cavity was diagnosticated. Dr. Baer was called in, and confirmed the diagnosis. The patient refused operative assistance, and preferred to die in peace, but five days later asked to be relieved. Preparations were made for laparotomy. An examination per vaginam revealed gangrenous pus escaping freely, and the placenta loose and hanging from the vagina; the hand passed readily through the os uteri and through a tear in the right wall of the cervix into the abdominal cavity, and came upon the trunk of the child. The latter was extracted through the vagina by version by the feet. It was putrid. The parts were well irrigated with carbolized water, and the hand, again introduced, entered an adventitious sac, and nowhere came in contact with intestines or other viscera. The uterus was well contracted, and quite small. The uterus and sac were washed out with carbolized water until it returned pure. The patient died of septicæmia ten days after the removal of the fœtus. Dr. Baer is in full accord with the principles advanced by Dr. R. P. Harris in his paper entitled, "If a Woman has Ruptured her Uterus during Labor, what should be done to save her Life?" (*Amer. Jour. Obst.*, October, 1880, p. 809), in which he advises that the abdomen should be opened and the peritoneal cavity thoroughly cleaned. In this case, however, nature had protected herself by forming an adventitious cavity, and there could be no reason to open the abdomen to clean this out, as it could be reached from below more directly and without injury to the soft parts.

Dr. HENRY M. FISHER: In Germany a distinction is made between lymphatic septicæmia and phlebitic septicæmia. In the first form the poison is absorbed by the lymphatics, and inflammation of serous surfaces with exudation is the consequence. In the phlebitic form numerous emboli are formed, and hectic fever and local pus-formations, the result of these emboli, are found. At the autopsy in this case, pleural and pericardial effusion was found. It will be remembered that peritonitis occurred very soon after the rupture.

Dr. GOODELL remarked that he had come intending to criticise Dr. Baer's treatment of this case for not resorting to laparotomy, but he found himself agreeing with both Dr. Harris and Dr. Baer. In recent cases laparotomy should always be performed, but in fifteen days an adventitious sac had been formed, and the danger to the patient would have been increased by operation. He had seen two cases of rupture of the uterus. Both of them occurred in the practice of a physician who never used obstetric forceps, and who had to send four miles for a consultant. In the first case peritonitis rapidly supervened, the abdomen became very much enlarged, and the fœtus could not be located by palpation. The abdomen was not opened. After long groping, the fœtus was found close under the diaphragm. He had great difficulty in extracting it, as the loops of intestines became entangled between its legs; the placenta was also found in the abdomen. In the other case the body of the fœtus had escaped

into the abdomen, but the head was still in the uterine cavity: it was delivered by forceps. Both patients died. In both cases it would have been far better to have opened the abdomen.*

Dr. HARRIS is in accord with Drs. Goodell and Baer as to the proper treatment of the case reported. It was too late to do anything when the physician was called. The general opinion is coming around to coincide with his way of thinking concerning the propriety of laparotomy in all cases as soon as reaction from the shock of rupture and hemorrhage has been established. Of the cases reported after such treatment, fifty per cent. have recovered. One woman has been reported as having ruptured the uterus in four successive labors with delivery per vaginam and without laparotomy, and survived it all; but such a case is phenomenal. Three cases in Europe have been treated by removal of the uterus, as in the Porro operation: they all died. There seemed to be no reason for such a method. In most cases the split extends through the cervix, and thus free drainage from the abdominal cavity is secured. One reason for closing the cervical rent by sutures is to avoid the danger of cancerous growths, to which that lesion is supposed to give rise.

Dr. LONGAKER remarked that many of these cases died from the profound shock and hemorrhage immediately following the accident. Two cases in his experience had died within two hours, one of them undelivered.

Dr. BAER was glad to hear Dr. Harris make the distinction as to the propriety of laparotomy in his case, where the patient was not seen until fifteen days after the accident and was suffering from septicæmia. He had intended to perform laparotomy, and was prepared for it, but when he found the newly-developed sac he changed his plan, as he thought nothing could be gained by it.

OVARIAN CYSTS.

Dr. BAER exhibited two ovarian cysts. Mrs. B., widow, entered his private hospital December 18, 1884. She commenced eight months before to suffer from frequent calls for micturition, with severe scalding pains,—symptoms apparently of cystitis and urethritis. The uterus and ovaries were in good position and seemed normal, but two weeks later there was a burning pain in both ovarian regions, with a perceptible bulging, largest on the right side. The menses had ceased, and the doctor in attendance suspected pregnancy, but exposure was denied at that time. The abdomen enlarged rapidly, and the patient finally acknowledged the possibility of pregnancy and thought she felt movements of the fœtus. At seven months uterine hemorrhages commenced, and continued every day; the mammæ were atrophied; there were no signs of the presence of a fœtus; there was some fluctuation; the sound was passed, and the uterus was found empty and not enlarged; the face was wasted and had an anxious expression, and the pulse was quick. A diagnosis of ovarian cyst was now made. A deep diagonal sulcus could be made out in the abdominal tumor, the largest portion being on the right side; the tumor was smooth-surfaced and without nodules. The cervix was soft, patulous, high up, and drawn to the left. When the tumor was moved the uterus moved with it, as shown by the handle of the sound. Immediate operation was advised and performed. Incision three and a quarter inches; two large tumors were revealed; both were tapped; the left, which was free from adhesions, was withdrawn without difficulty, its pedicle transfixed, ligatured, and dropped. The larger tumor, although free from abdominal adhesions, could not be drawn out, and it was found to be very tightly adherent to the uterus, which seemed to be one mass with it. As the fluid drawn from this tumor was clear, it is not improbable that it was a cyst of the broad ligament. It became necessary to enucleate the cyst, and a long, gaping wound was left in the broad ligament. This was transfixed and tied as a pedicle, but after the final division had been made the ligature slipped, and the hemorrhage was immense: ten hæmostatic forceps were applied temporarily, and the bleeding points were firmly secured. The wound of the broad ligament was closed by ten interrupted sutures. The operation lasted two and a half hours. The patient collapsed, and he feared she would die on the table, but she reacted, and recovery was uninterrupted. The patient sat up in two weeks. An incident which occurred on the fourth day shows the necessity of the proximity of a physician or thoughtful nurse. A scream from the patient; an announcement of a sudden pain on the right side; the patient said something seemed pulling inside of her. Dr. Baer was near, and was called. He feared internal hemorrhage, but at once inquired how long it had been since she had passed water. Four hours. The catheter was immediately used, and complete relief was secured. After this the catheter was not required until the tenth day, but from the tenth to the twentieth day there was entire inability to pass water except by assistance of the catheter. She went home on the twenty-third day.

The points of special interest in this case are:

1st. The patient being entirely well, symptoms of gonorrhœa presented themselves, and were followed by

2d. Amenorrhœa for seven months, followed by

3d. Daily hemorrhages for one and a half months.

4th. Ovaritis and large tumors forming in

* See Amer. Jour. Obst., vol x., 1877, p. 478.

eight and a half months from the initial symptoms.

Dr. BEATES. A young lady was obliged to separate from her husband one month after marriage, in consequence of domestic trouble. Her menses continued regular, but her abdomen enlarged as rapidly as if she were pregnant. Her health failed, and at the expiration of nine months an ovarian tumor was removed. Recovery was complete and rapid.

In another case he found numerous omental and enteric adhesions, which were easily separated, but pelvic adhesions required enucleation of the cyst, which left a large V-shaped wound in the broad ligament, as described by Dr. Baer. Hemorrhage was very free. In trying to dissect off the tumor from the fundus of the uterus, that organ was badly wounded. The cavity was opened, and required to be closed by sutures. Great tympany followed this operation, and breathing became almost impossible. The patient recovered.

CALCULI IN THE FEMALE.

Dr. J. W. SNOWDEN exhibited the stones, and related the history of the case. He was called, June 1, 1884, to see Mrs. L., aged 23 years. She was born and resided in a limestone region in New York.

Up to thirteen years of age she was troubled with anuresis, wetting the bed almost nightly. After this she ceased passing her urine during sleep, but was obliged to rise for this purpose two or three times during the night. She could not retain her urine, night or day, after the desire to pass it came on. If she could not reach a convenient place she would wet her clothes.

She married when seventeen years old. Two months after marriage she began to have cystic irritation, and soon passed sabulous matter and small calculi. These symptoms continuously increased. Physicians whom she consulted said she had catarrh of the bladder, but none made an examination for stone. Once she was obliged to call on a medical man to remove a calculus which had become impacted in the urethra.

Two years ago she spent a summer in New Jersey, during which time she passed no gravel, but the irritation of the bladder continued. When he first saw her she was urinating very frequently, with more or less pain. She passed stones daily, with a great deal of sabulous matter. The urine looked as if there was a quantity of ordinary sand in the bottom of the vessel. He proposed an examination for stone, which she refused peremptorily. He gave her benzoic acid, which entirely stopped the passage of the sabulous matter and relieved her in every way, but she still occasionally passed a small calculus. This marked relief lasted two or three months, when the irritation of the bladder became worse than ever. She could only pass her urine in the erect position, and with as much pain as a woman in labor. He again insisted upon an examination for stone, but the slightest touch excited such intense pain, even when she was well etherized, that, being alone, he could not manage her, and therefore sent for Dr. B. F. Baer in consultation.

A calculus measuring about one and a half inches in its largest diameter was found in the bladder, and removed by Dr. Baer after rapid dilatation of the urethra. This afforded marked relief, and she soon seemed entirely cured: but in a short time her urine began to dribble continually while she was in the recumbent position at night. During the day she retained and passed her urine naturally. He advised her to get up at stated intervals and empty her bladder, which had gradually relieved this trouble. She is now quite well, except that she urinates rather more frequently than is natural.

NEW YORK PATHOLOGICAL SOCIETY.

STATED MEETING, FEBRUARY 11, 1885.

The President, JOHN A. WYETH, M.D., in the chair.

A SPECIMEN of

CARCINOMA OF THE BREAST

was presented by Dr. WACKERHAGEN.

HYDROSALPINX.

Dr. CHAMBERS presented the right ovary and tube removed at the Woman's Hospital on the 17th of January. The patient had suffered from severe pain in the right side of the pelvis for eight years, and had had repeated attacks of localized peritonitis. The right ovary was found to contain a cyst about the size of a hen's egg, and was removed with the tube. The left ovary was very small, and so firmly adherent that the operator made no attempt to remove it. The patient made a very good recovery, and said she felt better than she had for many years.

THE COCCUS OF ACUTE LOBAR PNEUMONIA.

Dr. T. M. PRUDDEN presented specimens of the coccus of acute lobar pneumonia, described by Friedländer as being constantly present in that disease. Dr. Prudden had examined a large number of lungs the seat of acute lobar pneumonia, in all of which he found the coccus, and he had also found it in all specimens (ten in number) of bronchopneumonia in children which he had examined.

HYSTERECTOMY FOR UTERINE FIBROIDS.

Dr. H. MARION SIMS presented the uterus with eight fibroids, together with the ovaries and tubes, which he had removed from an unmarried woman, aged 31, suffering for a long time with frequent returns of the menstrual flow, which was excessive and preceded by pain across the abdomen. A tumor was

recognized, and, after palliative treatment for a year, laparotomy was performed. The patient was about the room five weeks after the operation.

EPITHELIOMA INVOLVING THE TIBIA AND THE OVERLYING SOFT TISSUES.

Dr. GEORGE F. SHRADY presented the leg of a man, 60 years of age, removed by the supra-condyloid amputation of the thigh for malignant disease. When the patient was about eighteen years old, a sore, probably caused by traumatism, developed over the shaft of the tibia, and had remained ever since. A year after the first appearance of the trouble he noticed a shell of bone at the bottom of the wound, which afterwards exfoliated. He got along with what seemed to be a simple ulcer until about two years ago, when pain obliged him to use crutches. About a year ago the ulcer took on a new form of action, spreading in different directions, and began to involve the tibia. The discharge became thin and sanious, and frequent and severe hemorrhages occurred. About seven months ago the patient noticed a false point of motion, and it was evident that the tibia was breaking down. Dr. Shrady saw him about a week ago, when it was plain that there was malignant disease of some nature, supposed probably to be scirrhus originating in the medulla of the bone.

Circumstances not permitting of a microscopical examination before the operation, a positive diagnosis was not then made. The ulcer itself presented very much the appearances of an epithelioma. Since the operation, microscopical examination by Dr. W. H. Porter proved that it was unquestionably epithelioma, which had apparently progressed from the skin and finally invaded the medullary cavity of the bone. It seemed to have been a case in which the disease began as an ordinary periostitis, increased, became a limited caries, osteo-myelitis, and finally, by continued irritation for forty years, the ulcer took on a malignant tendency and epithelioma developed. The upper portion of the tibia and condyles of the femur seemed to be entirely free from the disease, as was also the foot. He had never before seen a case in which epithelioma developed in the skin and progressed until it secondarily involved the bones of the leg. He thought that if an operation had been done some years ago, epithelioma would not have developed.

Dr. PORTER said Billroth spoke of epithelioma beginning in the integument and extending to the bone, cutting it in two.

Dr. RIPLEY doubted the last statement made by Dr. Shrady. Many men had a sore forty years and did not get epithelioma; many men had epithelioma not having had sores forty years; and it was possible for a man to have epithelioma forty years.

Dr. SHRADY replied that he agreed with Dr. Ripley entirely, but said it was quite possible, but hardly probable, that his doubt would be supported in practice. The clinical history of the case seemed to show very plainly that until comparatively recently there had been a benign sore, which had become malignant. This fact pointed out the danger to patients of allowing long-continued irritation to exist without submitting to an operation.

The PRESIDENT thought malignant disease often resulted from irritation, whether or not there were an hereditary tendency.

Dr. W. M. CARPENTER remembered to have heard Volkmann, of Halle, direct special attention to the liability of long-continued cutaneous irritation to give rise to malignant disease.

Dr. PORTER said that when he and Dr. Satterthwaite were preparing their report upon cancer, the conclusion to which they came was that in the majority of cases its origin was in long-continued irritation of some kind.

CARDIAC DISEASE: ERYSIPELAS FOLLOWING CUTANEOUS PUNCTURE FOR ANASARCA.

Dr. J. H. RIPLEY presented the heart removed from the body of a man, 27 years old, the patient having died in the St. Francis Hospital, February 6, 1885. He had been in the Hospital in June, 1884, with acute Bright's disease and mitral insufficiency. He was discharged improved, but returned in January, complaining of pain over the heart and swollen feet at night. There was general anasarca, hydrothorax, and cough. There were four cardiac murmurs: 1. Systolic, heard with greatest distinctness at the apex, conveyed posteriorly, loud and blowing in character. 2. Systolic, heard with greatest intensity at the base, transmitted up into the large vessel. 3. Diastolic, heard with greatest intensity at the xiphoid cartilage, circumscribed. 4. A slight superficial friction-sound at the junction of the second rib with the sternum on the left side.

The abdomen contained a large amount of fluid; there was dyspnœa and loss of appetite; the pulse irregular and feeble. Several punctures were made about the malleoli, inner aspect of the thighs, and scrotum; also on the left hand, which was much more œdematous than the right. A large amount of fluid dribbled away through the punctures, and the symptoms improved greatly. About a week after the punctures in the back of the left hand had healed, erysipelas developed in the extremity, and was one of the factors in causing death.

The points of interest in the case were, first, the development of erysipelas after puncture for œdema. While in this case the inflammation could not have been excited by the punctures, which had healed, in another case which had come under his observation

since Dr. Carpenter brought the question before the Society two or three years ago, the erysipelatous inflammation was evidently due to the punctures. These were the only two cases coming under his observation in which punctures for œdema had been followed by erysipelas. But it should not be forgotten that erysipelas was liable to develop in some cases whether or not puncture was made, and that the relief which the draining away of the fluid gave more than compensated for any slight increased risk of the development of cutaneous inflammation.

Second. At the autopsy the pericardium was found adherent to the heart throughout the entire extent, except near the base, and it was there that a slight friction-sound was heard. He had noticed in several cases of chronic pericarditis œdema of the left arm particularly.

Third. The heart was found to be immensely hypertrophied and greatly dilated; the mitral valve was the seat of stenosis, thickening, and insufficiency, and this led him to say, with regard to the so-called presystolic murmur occurring with stenosis of the mitral valve, that he thought it a very rare occurrence. He had examined this patient repeatedly and with great care, but no presystolic murmur was to be heard.

Fourth. Dr. Loomis stated that when there was adhesion of the pericardium to the walls of the heart and to the chest-walls, the apex-beat would be found above its normal position and not displaced to the left. In this case the apex-beat was displaced downward and to the left, showing that no general rule on this subject could be made.

Dr. VAN SANTVOORD thought Dr. Ripley's statement that a presystolic murmur was infrequent in mitral stenosis should not pass without comment. It was true that this murmur disappeared most readily during quietude, but to say that it was infrequent was too strong a statement. The murmur often existed as a prolongation of the first sound, and not as a distinct blowing sound, but on excitement it was readily recognized as a murmur. With regard to œdema of the left arm in chronic pericarditis, a few months ago he related a case in which there had been œdema of the right arm without local cause.

Dr. PORTER had made post-mortem examination in two cases in which mitral stenosis was diagnosed during life from the so-called presystolic murmur, and the diagnosis was confirmed. He thought there could be no question but that there was a murmur produced by obstruction to the flow of the blood from the auricle into the ventricle.

Dr. RIPLEY did not say that the murmur never occurred, but his own experience and that of Dr. Leaming and others was that it occurred rarely. The diagnosis of mitral stenosis was sometimes made, based upon the existence of a presystolic murmur, but could not be confirmed at autopsy.

Dr. CARPENTER had raised the question with regard to erysipelas occurring after puncture for œdema because an aged country physician, who had general anasarca due to cardiac trouble, desired to have the punctures made notwithstanding the liability to the development of erysipelas, and, the operation being performed, erysipelas developed, became phlegmonous, and ended fatally. Since then he had asked a number of surgeons their experience in this direction, and they always answered that they had not had erysipelas follow cutaneous puncture for œdema.

DIPHTHERITIC CAST OF THE TRACHEA AND BRONCHIAL TUBE.

Dr. RIPLEY presented a large piece of diphtheritic membrane, constituting nearly a complete cast of the lower portion of the trachea and one bifurcation of the bronchial tube, which he had extracted through a tracheotomy-wound. The operation was followed by relief from dyspnœa, and the child was then convalescing. Tracheotomy had been performed about the third day after the commencement of the disease.

TUBERCULOSIS OF THE LARYNX IN A CHILD TWO AND A HALF YEARS OLD.

Dr. VAN SANTVOORD presented specimens of apparent tuberculosis of a metacarpal bone and phalanx of one hand, and of the larynx, removed from the body of a child two years and seven months old. It was believed that syphilis could be excluded. Tuberculosis of the larynx in so young a subject was a very rare affection. The specimens were referred to the Microscopical Committee.

DESTRUCTION OF ONE LUNG IN A CHILD FOUR AND A HALF YEARS OF AGE.

Dr. S. J. MCNUTT presented specimens from the body of a child whose clinical history she could not give, illustrating complete destruction of the left lung, extensive degeneration of the right lung, and general tuberculosis throughout the body.

Dr. CARPENTER had recently made an autopsy on the body of a man in which there was almost complete destruction of one lung, with emphysema of the other.

NEW YORK ACADEMY OF MEDICINE.

A STATED meeting was held March 5, 1885, A. JACOBI, M.D., President, in the chair.

Drs. A. C. Post and John T. Metcalfe were unanimously elected Honorary Fellows.

THE ETIOLOGY AND TREATMENT OF NASAL CATARRH, WITH SPECIAL REFERENCE TO THE DEVIATED SEPTUM.

Dr. WILLIAM C. JARVIS read a paper with this title. The deviated septum might be

either osseous, cartilaginous, osteo-cartilaginous, or hypertrophic. Osseous deflection rarely occurred alone, being almost invariably associated with the cartilaginous form. The author then discussed the evil effects of pressure-irritation of the deviated septum upon the turbinated tissues opposite, and of defective drainage, as causes of nasal catarrh. He described the form of the floor of the nostrils at the back part, and of the arytenoid cartilages, which is specially adapted to direct the nasal secretion away from the larynx into the pharynx, where it was innoxious. To the deflected septum and turbinated hypertrophy he attributed nearly all the troubles arising from defective nasal drainage.

The causes of deviation of the septum are heredity, traumatism, and acquired conditions. One principal indirect cause of chronic nasal catarrh is a peculiar formation of the hard palate by which the nasal septum is forced to deviate from a straight line, and this malformation of the palatine arch is often transmitted from parent to children. One could diagnosticate chronic nasal catarrh by the form of the roof of the mouth. He emphatically rejected the prevalent idea of a diathesis or specific constitutional taint as the determining factor of nasal catarrh. There is another means of explaining the existence of nasal discharge which is so frequently found in intellectual men and women, without casting upon them such an odium. The encroachment of the cranial vault, in intellectual people, upon the bones of the face causes a deviation of the nasal septum, and thus leads to chronic nasal catarrh. The traumatic deviation of the septum is frequently seen in pugilists and persons of lower social life.

The treatment consists in a correction of the deviation of the septum, and this could be effected by certain instruments, a variety of which Dr. Jarvis exhibited. In order to reduce the sensibility of the parts before operating, he made use of a ten-per-cent. solution of cocaine, or, in extreme cases, of rhigolene. The latter anæsthetic easily exploded, and this could be guarded against by the use of the electric light.

Dr. F. H. BOSWORTH opened the discussion, and said that he and Dr. Jarvis had worked together for so many years that he did not expect to be called upon so soon to criticise him. Dr. Bosworth would drop the word nasal catarrh, as it simply signified discharge, which might be present in any form of nasal disease. He thought that the diagnosis of nasal affections had been rendered easy by the anæsthetic properties of cocaine. Dr. Jarvis laid stress upon pressure-irritation as an etiological factor in these troubles; this point had also been brought forward in the January number of *The American Journal of the Medical Sciences*, 1876, by Dr. Harrison Allen, at which time it gave rise to a great deal of comment. If two mucous surfaces in contact with each other in the nasal cavity give rise to irritation, the nasal cavity differs from other mucous cavities throughout the body. Dr. Bosworth did not believe the question of pressure-contact entered as an etiological factor at all. The pressure was an adventitious circumstance, depending upon hypertrophy of the mucous membrane, and gave rise to no symptoms at all. Nor did he believe that the nasal secretion was harmful, and consequently the question of nasal drainage did not come in as an etiological factor.

Deviated septum more than all other conditions combined acted as an etiological factor in nasal troubles, but it was not because it gave rise to pressure or defective drainage, but because it interfered with the normal function of the nose as a breathing-organ. The air, having to pass through the narrowed passage, became rarefied, and the venous sinuses became engorged with blood. The lecturer had expressed his disbelief in diathesis as an exciting factor of nasal troubles. But, unfortunately, he referred to a condition in illustration of his view which was pretty well recognized as being strumous,—namely, mollities ossium. He had seen the peculiar form of the palatine arch with deflection of the nasal septum, such as was referred to by Dr. Jarvis, in two cases.

As to treatment, the indications were clear,—namely, to remove the obstruction within the nasal passage; and this could be done with any instrument which the surgeon found to be most useful in his hands. As to cocaine as an anæsthetic, he had found a two-per-cent. solution sufficiently strong and costly.

Dr. S. O. VANDERPOEL, JR., had practised a method recommended by Dr. Roberts, of Philadelphia, for correcting a deviation of the nasal septum in five cases, the result in two cases being quite satisfactory, and in the others also more or less satisfactory. The operation consisted in retaining the deviated septum in its corrected position by means of a pin. The pin, being small, scarcely acted as a foreign body, and constituted no deformity while being worn.

Dr. D. B. DELAVAN said that one would be astonished, on examining a number of skulls, to find how many possessed a deviation of the nasal septum. But it was also true that the nostril on the concave side of the septum might be less patent than the other, due to an enlargement of the middle turbinated bone on that side. Therefore, removal of the mucous membrane and underlying tissues on the convex side of the septum did not always relieve the patient of his trouble, because it did not touch the abnormal condition on the opposite side. He thought, therefore, that the enlargement of the middle turbinated bone on the concave side of the septum should first receive treatment, and, if the patient were not

then relieved, the deviation of the septum might be corrected.

Dr. A. C. POST remarked that in stenosis from deviation of the septum, where it was necessary to remove a portion, the operation could be facilitated by transverse division of the columnæ and afterwards securing them in their replaced position by sutures.

Dr. JARVIS had used the word catarrh as the one most commonly employed. He had distinctly stated that the normal mucous secretion of the nose was harmless; but when, in diseased states, it became thick, it certainly possessed irritating and harmful properties. He agreed with Dr. Delavan that the malformation mentioned by him might exist, but it occurred only seldom. With regard to the use of pins, he could not get his patients to submit to that mode of treatment.

RECURRENT FIBROMA OF THE BREAST AT SEVEN AND ELEVEN YEARS OF AGE.

Dr. GEORGE G. HOPKINS, of Brooklyn, presented (under the microscope) a section of a fibroma of the breast which was first extirpated by a physician in the West when the little girl was seven years of age. The tumor, recurring, was, together with enlarged axillary glands, excised by Dr. Hopkins when the child was eleven years of age.

MEDICAL SOCIETY OF THE COUNTY OF NEW YORK.

A STATED meeting was held February 23, 1885, DANIEL LEWIS, M.D., President, in the chair.

CHOLERA: ITS MODE OF INTRODUCTION; ITS PREVENTION AND TREATMENT.

Dr. PETERS traced the origin of the different epidemics of cholera in this country to three different points,—namely, Quebec, New York, and New Orleans. Here he took occasion to allude to the theory that the germs of the disease were carried by the wind, and said that if this were the way in which cholera was introduced, points near the coast which vessels passed would have been infected before the cities mentioned. It was very difficult to find out the first case of cholera, inasmuch as the first death was likely to be of a resident who may have had no knowledge of exposure to the contagion in an immigrant or imported articles. Besides, several local points were liable to be infected about the same time by the sick visiting different privies. The disease, when introduced at Quebec, spread up the lakes, reached the Mississippi River, and went down to New Orleans. At nearly the same time that Quebec had its first cases there were also cases of cholera in New York. In 1848 the contagion was introduced simultaneously at New York and New Orleans. From New Orleans it was carried up the Mississippi, emigrants conveyed it among the Indians and to California, and it also reached San Francisco by vessels from New York. In 1854 the cholera broke out in New Orleans, and reached Niagara Falls before New York city saw the disease. In the spring of 1865 cholera started at Bombay, was carried by way of the Red Sea to Mecca by pilgrims, was brought by steamships to Marseilles, and finally reached New York in November. The cholera of 1873 entered New Orleans in what manner was unknown. While the citizens of Memphis were in ignorance of its existence in New Orleans, the cholera appeared in their city, and from there was carried to Nashville, where the greatest number of deaths took place. In that year Dr. Peters visited Cincinnati, to learn, if possible, the origin of cholera there, and he showed the difficulties to be overcome in such investigations. A hospital which was supposed to have had the first cases refused an examination of its books, and would only give the information that some cases of cholera had been in the wards, but all were then convalescing. Within about a week the matron, the senior physician, and his assistant all died of the disease. A stream of clear water came from the foot of the hill on which the hospital was situated, and was used by the people in the vicinity: it was not improbable that it contained the germs of cholera.

Bombay had had more or less of cholera since 1848, but after an improvement in the sanitary condition of the city the annual death-rate markedly decreased. Regarding the appearance of cholera in France in 1884, it was his opinion that it was carried from India by way of the Red Sea and the Suez Canal to Damietta, spread over Egypt, and finally reached Marseilles or Toulon. As was usually the case, in Damietta they placed a strong cordon of soldiers around the city to keep the cholera in, after thousands had fled and conveyed the cholera elsewhere. The rise of the Nile, he thought, was the chief means by which the contagion was driven out of Egypt. The speaker described the dirty condition and ill sewerage which existed in Toulon, and readily accounted for the spread of the cholera to Italy by the fleeing Italian workmen. It was a noteworthy fact that the cholera affected only such portions of Italy as were not malarious, a strong piece of evidence against the malarial origin of the disease, a theory to which some in this country, particularly in the South and West, still adhere. It was also a noteworthy fact that Lyons, France, had never had a severe visitation of the cholera. This was due, the speaker thought, to the excellent drainage and cleanliness effected through the rapid rivers Rhone and Saône. The efficiency of a well-enforced quarantine was seen in Denmark, which country had ever escaped the cholera by which its neighbors were afflicted

until on a given occasion when the quarantine was not enforced and the contagion was introduced into her borders. Greece had also escaped through means of an efficient quarantine until the Crimean war, when the quarantine was forced by the French and English soldiers.

Dr. Peters thought that cholera was always conveyed by caravans, clothing, ships, persons, and that the manner of its introduction into the human body was through the mouth. It was important to wash the hands frequently, and always to use clean water and a clean towel, during epidemics of cholera. The theories which had been advanced that cholera owes its origin to earthquakes or volcanoes, to ocean-currents, to the eating of watermelons, etc., need scarcely be mentioned. He did not think that summer diarrhœa had any connection with cholera; but when an endemic prevailed it would be well to treat all cases of diarrhœa as if of choleraic origin.

With regard to the treatment, he referred to an article on this subject which he published in a recent number of *The Medical Record*. It had been shown that a large number of the so-called cholera remedies were incapable of destroying the germs which were found in the dejections of a patient suffering from cholera except in very large quantities. Among the exceptions to this general rule was tannic acid; and it was Dr. Peters's opinion that the chief means for the relief of cholera was an acid.

RECENT RESEARCHES IN CHOLERA.

Dr. EDMUND C. WENDT read a paper with this title, in which he gave a lengthy review of the theories which had been advanced by different authors of the origin of cholera, and especially of the germ theory, which had received so much attention since the discovery by Koch of the comma-bacillus. It was the author's opinion that, although the question was not positively settled, the ground which had been taken by Koch was pretty firmly established.

ARTESIAN WELLS AS A SOURCE OF POTABLE WATER.

Dr. CYRUS EDSON, of the Committee on Hygiene, made a report on this subject. He quoted cases illustrative of the fact that in different cities contagious diseases, as cholera, had been spread by the inhabitants drinking of water from wells contaminated by the sewerage, and remarked that the wells furnished a sort of endless circulation,—well, man, privy, well. In Paris and some other cities the artesian wells gave water which was the drainage of the clean surface at a distance from the city, and it also passed through a chalk formation, which acted as a disinfectant. In New York the geological formation was such that the wells contained such water as drained from the surface above, and consequently contained the substances found in the sewers and the dirt of the streets, and would be an efficient means for the spread of cholera should the disease be introduced into the city. The Health Board had, therefore, interdicted the use of the water from the wells of the city except for manufacturing and chemical purposes. The breweries had not been interdicted its use in the manufacture of beer, because the water was subjected to a high degree of temperature in the process of manufacture, thus destroying all organic life. The water of the artesian well, being hard, was better for the brewing-business than was the water from the aqueduct.

GLEANINGS FROM EXCHANGES.

CHOLERA COMMISSIONS AND THEIR LESSONS.—In commenting upon the preliminary report of Drs. Klein and Gibbs, and Koch's publications upon the etiology of cholera, the *Indian Medical Gazette* says, editorially, "The lessons to be derived from these two Cholera Commissions, with their widely-divergent conclusions in dealing with the same subject, are very numerous and important, and ought to serve as a lasting caution against the premature formation and ready acceptance of speculative conclusions, based on uncertain and insufficient data. There is one important matter in this connection which cannot be too strongly condemned; that is, the reckless employment of argument by analogy in scientific investigations. From such an improper use of analogy nothing but discomfiture can be hoped for. Even when the intervening facts are correct, the process of arguing by analogy which Dr. Koch now takes to in every case is utterly inadmissible in scientific matters as equivalent to proof: it can only legitimately be used as affording a lead to experimental work in quest of proof. The process is a very double-edged one, and may be employed with curious results for the germists. The absolute folly that such a line of argument may lead to could not have been better illustrated than in the case of the comma-bacillus, where three negatives are assumed to be equal to one positive,—*i.e.*, typhoid fever cannot be experimentally shown to be due to a bacterial origin; leprosy is in the same condition; but because we have chosen to assume that the two former diseases are due to such an origin, we have in this assumption the proof that cholera is so also."

OXYGEN TREATMENT OF PHTHISIS.—Dr. Albrecht, of Neuchâtel, has submitted many of his patients in the Children's Hospital at Bern to the inhalation of oxygen, with a view to ascertaining its effects upon the development of phthisis, and whether by increasing

the rate of organic combustion by this means the bacterium of consumption would not be destroyed and eliminated from the system. The subjects were tuberculous patients in whose expectorations the bacterium of phthisis had been discovered with certainty on several occasions. The patients were first submitted to an appropriate highly-nutritious diet, consisting of milk and peptone, and twice a week they were weighed with great care. It was observed that as soon as the oxygen inhalations began, the daily loss of weight was checked, and in some cases the weight increased, dyspnœa diminished, and the number of bacteria seen under the microscope appeared smaller.—*New York Tribune.*

THERMONEUROSES.—In an article by Longuet, dealing with many of the phenomena of this subject, he makes the statement, at which few will cavil, that the nervous system exerts a direct influence on heat-production, not only in causing the highest degrees of temperature, but in giving the very low thermometric readings of collapse as well. He vigorously protests against the false interpretation which makes the term "hyperthermy" synonymous with the febrile condition. He attributes the various phenomena to the vasomotor action, but does not venture to advance any theory as to the mode of operation, contenting himself with the remark that the clinician has to wait until the physiologist throws some light upon his path.—*L'Union Médicale*, 4th and 6th January, 1885; *Edinburgh Medical Journal.*

BARBASCO.—Dr. L. Emmelheinz writes from Las Vegas to the *Medical World* in praise of barbasco, an indigenous plant of New Mexico and Arizona, which he recommends as a substitute for quinine, and also states that in small doses it is an excellent laxative, and in larger ones a drastic cathartic, producing much griping. The pulse and temperature fall under its influence, but it produces no head-symptoms like quinine. Although it has proved useful in intermittent and remittent fevers, the action is so different from quinine that it is hardly probable that it ever will effectually supersede it, although it is much cheaper. The fluid extract is made from the recent herbs; the dose of which is from ten to twenty drops in a teaspoonful of water every two to six hours.

From the statement of the writer that the plant is a "species of Croton," it is inferred that it is allied to the Croton Eluteria (Bennett) of the Bahamas, which was formerly employed in the treatment of intermittents, but has lost its reputation as an antiperiodic. The variety commonly known as Copalchi bark (Croton Pseudo-China of Schiede) "is an aromatic tonic employed in Mexico in intermittents, and capable of useful application in all cases requiring a mild aromatic bitter."—*United States Dispensatory*, 1883, page 366, foot-note.

MISCELLANY.

REFORM IN MANAGEMENT OF A HOSPITAL FOR THE INSANE.—The managers of the Morristown Insane Asylum of New Jersey have decided upon making a change which will probably exercise an important influence upon the treatment of the insane in this institution. The business management of the hospital is to be placed in the hands of a warden, so that the medical director and his four assistants can devote their entire attention to the care of the patients. Feeling that this innovation has attracted general attention, and knowing how much is involved in it, the medical officers, we are confident, will use every effort to make the experiment successful.

THE WAGNER HYGIENE ASSOCIATION has published a prospectus of a "Philadelphia Sanitary Protective League." The proposed organization is to be a voluntary one formed by citizens with a view to placing the city of Philadelphia in better condition to pass through a cholera siege. It will render such aid as lies in its power to sustaining and stimulating the health authorities in their work, by improving the sanitary condition of private houses, looking after the health of employees, and by a system of public lectures on hygiene. Branch committees will be formed all over the city. The main office is at 2246 Ridge Avenue, where C. C. Vanderbeck, M.D., the Secretary, can be addressed for further information.

THE Minister of Public Worship in Germany has lately assured himself that vivisection is advantageous to science, and he has issued regulations regarding the conditions under which it may be practised.

1. Experiments upon living animals can only be carried out for the objects of scientific investigation or instruction. 2. In public lectures these experiments can only take place when they have special reference to the subject that is under study. 3. The preparation for the experiments must be made before the lecture, and not before the public. 4. The experiments must be made by the professors or their assistants under the personal responsibility of the professors. 5. All experiments tending to the same results in the lesser animal species as on the higher must be made on the former. 6. All animals must, when possible, be subjected to anæsthesia during the experiments.

WOMAN'S MEDICAL COLLEGE.—The thirty-third annual commencement of the Woman's Medical College of Philadelphia was held at the Academy of Music on the 11th instant, graduating a class of twenty-two. W. W. Keen, M.D., delivered the address, and T. Morris Perot, Esq., President of the Board of Corporators, conferred the degrees.

THE MARINE HOSPITAL SERVICE.—It has been stated by a Washington paper that the veteran sanitarian Dr. A. N. Bell is a candidate for the position of Supervising Surgeon-General of the Marine Hospital Service. This would be an appointment which we feel sure would receive the hearty sanction of those who are most active in their efforts in behalf of public health, both in and out of the ranks of the profession.

NOTES AND QUERIES.

TO THE EDITOR OF THE PHILA. MEDICAL TIMES:

DEAR SIR,—I read with much interest the case reported in your number for March 7, by Dr. Henry M. Wetherill, Jr., of *Morbus Maculosus Werlhoffii*. I would like to repeat with him that "I should be exceedingly glad to learn more of this singular affection, and would be obliged to any of my professional brethren for further enlightenment upon this subject."

In a well-marked case under my care last summer I was entirely persuaded that the affection was the result of nervous exhaustion. The patient was a gentleman in the prime of life and in high position, who had been overworked and worried and kept in a state of anxious suspense for several weeks.

Ziemssen (vol. xvii p. 269) tells us that the theory of a neurotic disease of the blood-vessels is perhaps more tenable than any other in explaining those very rare cases of acquired and transitory hemorrhagic diathesis. This theory was suggested by some recent experiments performed by Nothnagel on animals, which prove that multiple hemorrhages occur in the lungs after slight lesions of certain points in the cortex of the brain.

The case I refer to here is the only one I have ever met with where the hemorrhagic affection had every character of an *essential disease:* that is, one not symptomatic, not developed on the foundation furnished by another well-defined primary disease, such as variola, typhus, phosphorus-poisoning, leukæmia, protracted icterus, or progressive pernicious anæmia.

The primary cause of this affection must of course be looked for in some disturbance of the physiological relations existing between the blood and the walls of the blood-vessels. The results furnished by examinations of the blood are negative, and there is also an absence of all macroscopic changes in the walls of the vessels. It would seem that the difficulty must be located in the nervous centres presiding over the calibre and tonicity of the vessels.

Prof. D. Hayes Agnew saw the case that came under my care together with me, and he informed me that he had seen a case once before, and in this, a young lady, the affection he was confident was the result of a violent fall on the back while skating. Respectfully yours,

WALTER F. ATLEE, M.D.

210 SOUTH THIRTEENTH STREET.

OBITUARY.

ELLERSLIE WALLACE, M.D., Emeritus Professor of Obstetrics in the Jefferson Medical College, died March 10, at his residence in this city. He was a native of Philadelphia, was born June 15, 1819, and was of Scotch descent. He received his academic education at Bristol College, and then entered the Jefferson Medical College, from which he was graduated in 1843. He was then elected resident physician of the Pennsylvania Hospital, a position which he ably filled for three years. He resigned to become Demonstrator of Anatomy in the college from which he was graduated in 1846, and held this position for sixteen years.

In 1863, Dr. Wallace became Professor of Obstetrics and Diseases of Women and Children in the College, being the immediate successor of Prof. Charles D. Meigs, and filled with distinction this position until 1883, when he resigned on account of failing health. He also filled the position of Dean of the College as the successor of Prof. Biddle. Two weeks ago he became very much worse, and death resulted from erysipelas of the head. A physician of thorough knowledge of general medicine as well as of his special department, he had a large family practice. Of a retiring disposition, he shrank from entering the lists with those who write for notoriety, and therefore only occasionally contributed articles to medical journals. As a lecturer he had few equals, being possessed of a special faculty of imparting knowledge, his lectures being demonstrative and frequently abundantly illustrated.

Dr. Wallace had a large sympathy, a broad philanthropy, a heart full of Christian kindness, and a genial nature, which endeared him to his patients and made for him many warm professional friends, by whom his loss will be deeply felt.

HOWARD HOSPITAL AND INFIRMARY FOR INCURABLES,
PHILADELPHIA, February 27, 1885.

At a special meeting of the members of the Medical Board, held this day, called to take action upon the recent decease of the late President of the Board, it was

Resolved, That the members of this Board feel that in the death of Joseph Klapp, M.D., they have sustained a severe loss.

A gentleman who, by his eminent skill and devotion to his profession, and his conscientious performance of all the duties pertaining to his official position, and the unwavering interest ever shown by him in his devotion to the welfare and success of this hospital; by his courtesy and kindness to his fellow-members and his urbanity, always manifested as well to general society as to his professional brethren, has endeared himself to the members of this Board, who will ever cherish with kindest regard the remembrance of his many noble and manly traits.

Resolved, That we hereby express our warm and high appreciation of his professional services gratuitously rendered this hospital during an unbroken period of more than thirty years, in a spirit of unwavering devotion to and earnest desire for its prosperity.

Resolved, That we tender to his family the expression of our earnest sympathy in their bereavement, and pray that a loving Providence may soothe and alleviate their great sorrow and loss.

Resolved, That, as an expression of our sincere regard and esteem for his memory, we will attend his funeral in a body.

Resolved, That the foregoing be entered upon the minutes, and a copy be sent to the family.

T. HEWSON BRADFORD,
Secretary.

OFFICIAL LIST

OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT U.S. ARMY FROM MARCH 1, 1885, *TO MARCH* 14, 1885.

ARMY MEDICAL BOARD to meet in New York City, April 6, 1885. Detail for Board: Lieutenant-Colonel Joseph B. Brown, Surgeon; Major Anthony Heger, Surgeon; Major John H. Janeway, Surgeon. Surgeon Heger to be relieved from duty in Department of the East, and Surgeon Janeway to perform duties on the Board in addition to his present duties. S. O. 56, A. G. O., March 11, 1885.

BYRNE, CHARLES C., MAJOR AND SURGEON.—Ordered to Department of the East on expiration of his present leave of absence. S. O. 50, A. G. O., March 3, 1885.

BROWN, H. E., MAJOR AND SURGEON.—Granted leave of absence for one month, with permission to apply for two months' extension. S. O. 48, Department of the East, March 6, 1885.

WOODRUFF, EZRA, CAPTAIN AND ASSISTANT-SURGEON.—Ordered for duty at Fort Maginnis, Montana Territory. S. O. 23, Department of Dakota, February 25, 1885.

TAYLOR, BLAIR D., CAPTAIN AND ASSISTANT-SURGEON.—Leave of absence extended two months. S. O. 54, A. G. O., March 9, 1885.

PORTER, J. Y., CAPTAIN AND ASSISTANT-SURGEON.—Sick-leave of absence further extended fourteen days on account of sickness. S. O. 51, A. G. O., March 5, 1885.

EWING, C. B., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Having relinquished unexpired portion of leave of absence, ordered for temporary duty in the field. S. O. 23, Department of Missouri, March 2, 1885.

RAYMOND, HENRY I., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—(Recently appointed.) Ordered for duty in Department of California. S. O. 50, A. G. O., March 3, 1885.